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UNIVERSITY OF ALBERTA

An Historical Perspective of Comfort in Nursing Care

BY

Kathleen Frances Hunter McIlveen

A thesis submitted to the Faculty of Graduate Studies and Research in partial fufillment of the requirements for the degree MASTER OF NURSING.

FACULTY OF NURSING

Edmonton, Alberta

Spring 1992

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled AN HISTORICAL PERSPECTIVE OF COMFORT IN NURSING CARE submitted by KATHLEEN FRANCES HUNTER MCILVEEN in partial fufillment of the requirements for the degree of MASTER OF NURSING.

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October 18, 1991

DEDICATION

This thesis is dedicated to my husband Mark and daughters Laura, Linda and Erin who were patient and supportive of my efforts always. Additionally, the thesis is dedicated to the memory of my colleague and beloved friend, Lori Lawton-Anderson.

ABSTRACT

Comfort, a concept long associated with nursing, has never been clearly defined. Historical study is recognized as an important way in which to come to an understanding of the present through examination of the past. In this study, the role and significance of comfort in nursing care from 1900-1980 was examined in order to ascertain the evolution of the concept of comfort in nursing. Excerpts from 17 nursing textbooks and 634 Canadian, American and British journal articles written by nurses were coded for the key words comfort, comfortable, comforting, uncomfortable, discomfort and pain. The first level of analysis was a content analysis of this coded data from which twelve categories of comfort emerged. A second level of analysis placed the categories in a time perspective from which three periods of comfort emerged. Comfort was found to have moved from being the focus of nursing care to being one of many of nursing goals and strategies, except for incurable patients for whom comfort remained consistently the goal of nursing care. Taxonomies of physical and emotional comfort strategies were developed for each of the three periods. Type of employment (private duty/institutional), physician control, technology and nursing science are seen to influence the changes in comfort over time.

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LIST OF ABBREVIATIONS

AJN	American Journal of Nursing
BJN	British Journal of Nursing
CINL	Cumulative Index to Nursing Literature
CN	Canadian Nurse
CNHR	Canadian Nurse and Hospital Review
NANDA	North American Nursing Diagnosis Association
NT	Nursing Times
NW	Nursing World

CHAPTER 1

INTRODUCTION

Comfort is a word traditionally associated with nursing care and it has been used by many authors in different ways. Morse described comforting as the "major instrument of care in the clinical setting".[1] Hodgman[2] maintained that along with nurturing, caring and support, attention to comfort is part of the core of nursing. Comfort, as viewed by these authors, is one of the preeminent concepts in nursing.

Some nursing theorists have envisioned comfort not as the premier concept in nursing but rather as one which is subsumed under a broader abstraction. Leininger[3] includes comfort under caring as one of many caring constructs in a taxonomy developed for the purpose of

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[1]Janice Morse, "An Ethnoscience Analysis of Comfort: A Preliminary Investigation," Nursing Papers 15 (1983): 6.

[2]E. Hodgman, "Excellence in Nursing," Image 11, no. 1 (1979), 23.

[3]Madeline Leininger, Caring: An Essential Human Need: Proceeding from the Three National Caring Conferences (New Jersey: Clarke B. Slack, 1981), 115.

studying transcultural nursing. Watson[4] also encompassed comfort within caring as part of one of the carative factors dealing with the environment and described it as external variable which the nurse could control. Physical, mental, and spiritual comfort as well as the influence of sociocultural values on perceptions of comfort are acknowledged. She also inferred that too much comfort could lead to dependency.

The problem explored in this study was derived from the lack of clarity and consensus in the use of the concept of comfort in nursing literature. Whether or not nurses have thought of comfort in the same way for many years or whether the association of comfort with dependency and possible emphasis on its physical aspects is a recent development, is not known. Nurses continue to discuss comfort as an abstract concept, without a sense of how the concept evolved historically within nursing.

A historical study was undertaken using as a first level of analysis the qualitative method of content analysis. Data were obtained from accounts of how nursing care was provided from 1900 to 1980, from Canadian, American, and British nursing textbooks and

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[4]Jean Watson, Nursing: The Philosophy and Science of Caring, 2d ed., (Boulder, Colo.: Colorado Associated University Press, 1985), 9.

journals, as well as descriptions of actual care given to patients. Many rich sources were found. Reading through these accounts and descriptions was a time consuming process in order not to miss any key words. A second level of analysis was undertaken to place data into the period and to synthesize from this a conceptualization of how nursing care has evolved.

CHAPTER 2

LITERATURE REVIEW

To understand how nurses interpret the word comfort, it is useful to understand the original meaning of the word. Comfort is derived from the Latin word confortare, which means to strengthen. It is actually comprised of two Latin words, the prefix con, which means with or together, and fortis, which means brave.[1]

Common usage of the word comfort has undergone some transformation during this century. The association of the idea "to strengthen" and "to make strong" with comfort in verb form was common early in the century,[2] reflecting the origin of the word. As the century progressed, this meaning of the verb was either omitted[3]

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[1]An Etymological Dictionary of the English Language 1910 ed., s.v. "Comfort."; An Etymological Dictionary of Modern English, 1967 ed., s.v. "Comfort."; The New Webster Encyclopedic Dictionary of the English Language, rev. ed. (1984), s.v. "Comfort."

[2]New Revised Encyclopaedic Dictionary, rev. ed. (1902), s.v. "Comfort."; An Etymological Dictionary of the English Language, 1910 ed., s.v. "Comfort."

[3]The King's English Dictionary, 1923 ed., s.v. "Comfort."

or eventually listed as obsolete.[4] The meaning of the verb comfort that became the more common usage is to relieve, soothe and/or console in grief or mental distress.[5]

In the noun form, there was a similar disassociation of strength with comfort. Early meanings of the noun comfort included the "strength or relief"[6] received in affliction or weakness, as well as a state or cause of "quiet enjoyment"[7] and "freedom from trouble, pain, or disquiet."[8] Later, the noun was defined as a "state or feeling of relief"[9] or "freedom from pain"[10] or "well-

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[4]Webster's New Collegiate Dictionary, 1949 ed.; The Concise Oxford Dictionary of Current English, 4th ed., (1951); The Concise Oxford Dictionary of Current English, 5th ed., (1964); The Concise Oxford Dictionary of Current English, 6th ed., (1976); Webster's 3rd New International Dictionary, 1986 ed.; The Oxford English Dictionary, 2nd ed., (1989), s.v. "Comfort."

[5]Ibid.

[6]Crabb's English Synonyms, 1916 ed., s.v. "Comfort", New Revised Encyclopaedic Dictionary, 1902 ed.; The King's English Dictionary, 1923 ed..

[7]Ibid.

[8]Crabb's English Synonyms, s.v. "Comfort".

[9]Webster's New Collegiate Dictionary, s.v. "Comfort".

[10]Ibid.

being, being comfortable"[11] or that which produced such a state.[12] The idea of strength was no longer included in the definition, but relief continued to be associated with comfort.

Whether or not the meaning of comfort in nursing care has undergone such a transformation is unclear. Recently, Kolcaba[13] acknowledged the changing dictionary definitions of comfort but questioned whether nursing practice had followed suit, and suggested that some element of strengthening still remained in the comfort provided by nurses. It is difficult to ascertain if this pronouncement is accurate as comfort in nursing care "has not been defined, and remains abstract"[14], although attempts at definition have been made.

Current attempts to interpret comfort by the North American Nursing Diagnosis Association (NANDA) have

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[11]Concise Oxford Dictionary, 4th ed.; Concise Oxford Dictionary, 5th ed.; Concise Oxford Dictionary, 6th ed. s.v. "Comfort."

[12]Webster's New Collegiate Dictionary, 1949 ed.; Concise Oxford Dictionary, 4th ed.; Concise Oxford Dictionary, 5th ed.; Concise Oxford Dictionary, 6th ed.; Oxford English Dictionary, 2d ed., s.v. "Comfort."

[13]Katherine Kolcaba, "An Analysis of the Concept Comfort," Journal of Advanced Nursing (in press-manuscript): 6-7, 18.

[14]Janice Morse, "An Ethnoscientific Analysis of Comfort: A Preliminary Investigation", Nursing Papers 15 (1983): 7.

resulted in describing a state of physical discomfort, such as pain or nausea, under the heading of Comfort, Altered.[15] Evaluation has found the category to be in need of further refinement[16] although the lack of inclusion of psychosocial dimensions of comfort is not specifically noted. Since other authors and researchers have included psychosocial aspects of comfort[17] in their work, the NANDA definition is not reflective of a consensus on the definition of comfort as it relates to nursing care.

There has been relatively little work in nursing research which pertains directly to the identification of

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[15]Classification of Nursing Diagnosis: Proceedings of the Eight Conference of the North American Nursing Diagnosis Association (Philadelphia: J. B. Lippencott, 1989), 513; L. Carpenito, Nursing Diagnosis: Application to Clinical Practice 3d ed. (Philadelphia: J. B. Lippencott, 1989), 193-226.

[16]Teresa Gyldenvand and Patricia Tunick, "Validation of the Nursing Diagnosis Alteration in Comfort: Chronic Pain" in Classification of Nursing Diagnosis: Proceedings of the Eighth Conference of the North American Nursing Diagnosis Association (Philadelphia: J. B. Lippencott, 1989), 282-290; Rona Levin, Barbara Krainovich, Erma Bahrenburg, and Carol Ann Michell, "Diagnostic Content Validity of the six Most Frequently Cited Nursing Diagnostic Categories: A Construct Replication," in Classification of Nursing Diagnosis: Proceedings of the Eighth Conference of the North American Nursing Diagnosis Association (Philadelphia: J. B. Lippencott, 1989), 356-358.

[17]Research examining the psychosocial aspects of comfort will be reviewed in upcoming pages of this chapter.

the many dimensions of comfort. The reason for this may be that early nurse researchers did not deem comfort as worthy of investigation, and that it is only recently that new nurse scholars have started to explore such elements of nursing.[18] Most of the studies which have been completed have looked at present day nursing care, few have analyzed nursing care in the past. Investigations from the perspective of the nursing staff and of the recipient of comfort have both been undertaken.

Studies examining comfort from the perspective of the nursing staff have looked at comfort in intensive care[19], across age groups[20], and in the terminally ill.[21] Estabrooks[22] developed a taxonomy of touch used

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[18]Afaf Meleis, Theoretical Nursing: Development and Progress 2d ed. (Philadelphia: J. B. Lippencott, 1991), 118.

[19]Carole Estabrooks, "Touch: A Nursing Strategy in the Intensive Care Unit," Heart and Lung, 18 (July 1989): 392-401.

[20]Sharon Burke and Mary Jerrett, "Pain Management Across Age Groups," Western Journal of Nursing Research 11 (April 1989): 164-180.

[21]Barry Lunt and Judith Jenkins, "Goal-setting in Terminal Care: A Method of Recording Treatment Aims and Priorities," Journal of Advanced Nursing 8, no. 6 (1983): 495-505; Cornelia Fleming, Colleen Scanlon, and Nancy D'Agostino, "A Study of the Comfort Needs of Patients with Advanced Cancer," Cancer Nursing 10, no. 5 (1987): 237-243.

in the intensive care setting and identified comforting touch from a psychosocial view as a type of caring touch. It's use was associated with dying, discomfort, and grief. Comforting touch was differentiated from touch which occurred in order to perform a physical task or to protect (restrain) the patient. The study carried out by Burke & Jerrett[23] focuses not on psychosocial comfort but rather on physical comfort through the relief of pain. Pain interventions such as use of medication and other physical measures were selected more frequently overall by student nurses than were measures such as massage/touch, distraction and imagery. Estabrooks used a psychosocial approach to comforting while Burke and Jerrett focused on only one physical dimension of comfort.

Lunt and Jenkins[24] attempted to operationalize comfort and rehabilitation in a terminally ill hospice population through use of goal lists developed by medical and nursing staff. Physical comfort goals referring to the control of pain, nausea and vomiting, and other physical symptoms were more frequently identified by

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[22]Estabrooks, "Touch", 395.

[23]Burke and Jerrett, "Pain Management", 164-165.

[24]Lunt and Jenkins, "Goal-setting", 496, 501.

staff in patients whose stay ended in death than for those who were discharged. From the point of view of the staff, it seems that patients close to death have different comfort requirements than do those for whom death is not so imminent. Comfort in this study referred to eight physical aspects and only one psychological aspect, that of "anxiety, depression and mood."[25] The aspects of information on the illness and family problems were separated out of the comfort category into another category titled "other."[26] Physical aspects of comfort were emphasized.

In contrast to this, Fleming, Scanlon and D'Agostino[27] found that nursing staff in a cancer hospital identified providing psychosocial comfort measures slightly more frequently than physiological measures and concluded that the staff have a perception of comfort as multifaceted. The difference between the two studies is probably again due the different definitions of comfort used by the researchers. The Lunt and Jenkins study included the input of physicians in the goal identification and separated information giving and

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[25]Ibid, 501.

[26]Ibid., 501.

[27]Fleming, Scanlon, and D'Agostino, "Comfort Needs", 241-242.

family concerns out of comfort while Fleming, Scanlon, and D'Agostino used the standards of practice of the Oncology Nursing Society whose reported definition of comfort is much broader.[28]

Several researchers have investigated comfort from the perspective of people who receive comfort, primarily patients. Gardner and Wheeler[29] looked at comfort indirectly by way of patients' perceptions of support and found that promoting comfort was the second most frequent category of support which emerged in analysis. Unfortunately, the definition of comfort used is not made explicit and many of the dimensions of comfort identified by other researchers are separated into categories of their own. For example, availability of the nurse, relief of pain, performing specific nursing tasks, friendly attitude of the nurse and giving reassurance are separate from promoting comfort. One must infer from the text that comfort, as used by these researchers, is physical

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[28]Fleming, Scanlon and D'Agostino report the definition of comfort according to the Oncology Nursing Society as minimizing biopsychosocial distress and give the reference for this as: Oncology Nursing Society: American Nurses Association of Medical-Surgical Nursing Practice, Outcome Standards for Cancer Nursing Practice (Kansas City, Missouri: American Nurses Association, 1979), 5.

[29]Kathryn Gardner and Erlinda Wheeler, "Patients' Perceptions of Support," Western Journal of Nursing Research 9, no. 1 (1987): 115-131.

comfort provided by the nurse by activities such as positioning and backrubs.

Other researchers have been clearer and more direct in their approach to comfort. Tripplett and Arneson[30] used tactile (touch) and verbal comfort effectively to alleviate the distress (crying) of young children who were hospitalized and gave operational definitions of these. Morse[31], in a preliminary investigation of the dimensions of comfort found that informants described three segregates of the act of comforting as touching, talking and listening. Touch "appeared to meet psychological rather than physiological needs."[32] Hamilton[33] found that among terminally ill and chronically ill elderly, the presence of friendly, caring and empathetic nurses, as well as relief of pain and satisfactory positioning, was part of feeling

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[30]June Tripplett and Sara Arneson, "The Use of Verbal and Tactile Comfort to Alleviate Distress in Young Hospitalized Children," Research in Nursing and Health 2, no.1 (1979): 17-23.

[31]Morse, "Ethnoscience Analysis", 6-20.

[32]Ibid, 17.

[33]Joan Hamilton, "Comfort on a Palliative Care Unit: The Client's Perspective" (Master's Thesis, McGill University, 1985); Joan Hamilton, "Perceptions of Comfort by the Chronically Ill Hospitalized Elderly," in Key Aspects of Comfort: Management of Pain, Fatigue and Nausea, ed. S. Funk and others (New York: Springer, 1989), 281-289.

comfortable. From the perspective of recipients of comfort, it appears that psychosocial as well as physical aspects are involved.

Little work has been done in the area of the historical aspects of comfort in nursing care. Pearman[34] looked at the emotionally-supportive and patient-teaching roles of the nurse from 1900 to 1970 but acknowledged comfort only incidentally in the codified guide used to evaluate the historical data. In the analysis, comforting was noted as one of the descriptors of a good nurse from the early part of the period studied but in later periods nurses were found to be expected to "emotionally support" patients and use "therapeutic nurse-patient communication."[35] The possibility of change in what nurses saw as comfort or even called comfort appears to be suggested by the data but was not discussed. Stinson did discuss a change in comfort by proposing that the "comfortability"[36] of patients changed from physical to emotional emphasis with the onset of medical advances as

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[34]E. Pearman, "Historical Study of the Emotionally-Supportive and Patient-Teaching Roles of the General Duty Nurse" (Ph.D. diss., Boston University School of Education, 1971).

[35]Ibid., 175.

[36]Shirley Stinson, "Deprofessionalization in Nursing?" (Ph.D. diss., Teachers College, Columbia University, New York, 1969), 322-324.

antibiotics in the latter half of this century, although comfort was not the primary focus of her work.

Review of present day nursing research regarding comfort shows a lack of unanimity regarding the definition and dimensions of comfort. For some, comfort is physical care and nursing actions such as being with the patient and giving reassurance falls under some other category such as support. For others, comfort includes psychosocial dimensions or a combination of physiological and psychosocial aspects. The reason for such a diversity of definitions of comfort in the literature is unknown but some possibility of a change in the meaning of comfort over time is suggested by historical work.

The purpose of this study was to explore and understand the background behind the divergent views held on comfort presently. This was carried out by seeking to describe change in the connotation and use of comfort in nursing literature. The specific research question was: What is the role and significance of comfort in the nursing literature from 1900 to 1980?

CHAPTER 3

METHODS

The study made use of a qualitative historical design in order to examine the question stated at the end of the previous chapter. Qualitative methodology is predominant in historical research.[1] The investigator worked inductively, developing categories of comfort from the data. Insights into changes in these categories evolved and were depicted in light of the time period the study covered.

Parameters of the Study

The period of time 1900 to 1980 was chosen as it represented a period of proliferation of nursing literature, both journals and texts. Prior to the beginning of this century, few nursing textbooks were in print[2]. In 1900, the American Journal of Nursing commenced publication and was soon followed by the Canadian Nurse and Hospital Review (later the Canadian

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[1]Mary Sarnecky, "Historiography: A Legitimate Research Methodology for Nursing," Advances in Nursing Science 12, no. 4 (1990):6.

[2]E. Flaumenhaft and C. Flaumenhaft, "American Nursing's First Textbooks," Nursing Outlook 37, no. 4 (1989): 185.

Nurse) in 1905. An increased number of graduate nurses had access to professional literature. As the century progressed, the number of available journals and texts increased.

Not only was the amount of available literature increasing but the ideas being discussed in the literature were becoming more complex. Although Christy[3] had suggested allowing twenty years to pass before attempting historical analysis, the study examined up to 1980 rather than stopping at 1970. The rationale for this was that a change in the use of comfort in the 1970's was foreseen to be a possibility as this was the time when the desirability of developing nursing conceptual frameworks for the purpose of articulating a distinct body of knowledge began to be recognized.[4] Prior to this, much of the literature was seen to be without explicit theory or used theory developed in disciplines other than nursing or for a single area of practice. The inclusion of this decade was felt to be important as meaningful insight into the role of comfort that might have overlooked had it been excluded.

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[3]Teresa Christy, Dr. Teresa Christy's Methodology of Nursing Research, part 1, produced by the University of Iowa: College of Nursing. Videocassette.

[4]J. Fawcett, Analysis and Evaluation of Conceptual Models of Nursing, 2d ed. (Philadelphia: F. A. Davis, 1989).

Data Collection and Analysis

Sources

Qualitative research can make use of either human to human methods, such as interview data, or artifactual methods, such as documents or records.[5] This study used an artifactual method as the sources were historical documents, published nursing journals and texts. Primary sources are materials in existence at the time of the event and were written by persons claiming first hand knowledge of the event, while secondary sources contain second hand reports or the results of another investigation of a primary event, such as accounts found in history books[6]. A primary source was held to be a case study of nursing care given to a particular patient or description of how to give nursing care in general or specific circumstances written by a nurse or student nurse[7] in nursing journal and textbooks. Articles on how

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[5]Y. Lincoln, "Connections Between Qualitative Methods and Health Research," Keynote address at the Qualitative Health Research Conference, Edmonton, Alberta, 22-23 February, 1991.

[6]Holly Wilson, Research in Nursing (Menlo Park, California: Addison-Wesley, 1985), 133; J. Benjamin, A Student's Guide to History, 4th ed. (New York: St. Martens Press), 7.

[7]Articles by student nurses were included because for the majority of the time period studied, student nurses provided most of the direct patient care in hospitals as most nursing education programs were of the apprenticeship type. For further reading on this subject, refer to Canadian Nurses' Association, The

to give nursing care written by physicians were considered secondary sources as it would impossible to determine if the physician was present during actual nursing care or not. Primary sources, in the form of articles in nursing journals and nursing textbooks written or during the time period of the study were used exclusively for the first part of the study, the content analysis, as there proved to be a wealth of such data available, especially from the later years. Secondary sources in the form of books on nursing and medical history as well as previous historical investigations were invaluable and used as well as primary sources in the second part of the analysis which examined the categories of comfort in light of the period of time spanned and events which occurred.

Data Collection

Potential sources were examined and data on comfort was sought by searching for key words such as comfort, comfortable, pain, discomfort and uncomfortable and other derivatives of comfort such as comforting in articles describing nursing care. Textbooks were examined by searching tables of content and indexes for key words, then searching through appropriate sections for further

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Leaf and the Lamp, (Canadian Nurses' Association, 1968), 3-6; P. Kalisch and B. Kalisch, The Advance of American Nursing, (Boston: Little Brown Co., 1978), 185-186, 593-596.

use of key words.

Data collection began with examining nursing textbooks in use between 1900 and 1980. Early nursing textbooks used into the 1930's which had wide readership were identified through articles on the subject[8] as well as book lists from suggested curriculums.[9] Later textbooks were selected for their availability as well as general nature of subject matter, such as textbooks of introductory or general medical-surgical nursing. More specific textbooks (i.e. pediatric or obstetrical) were not included as data a wealth of rich data was obtained from journal articles. The on-line catalogue at the John Walter Scott Library at the University of Alberta was used to identify nursing texts in that collection and other texts were made available from private collections of individuals.

At the same time as the data was being collected from textbooks, initial identification of possible journal sources was made through a manual literature search using the Nursing Studies Index, 1900 to 1959

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[8]E. Flaumenhaft and C. Flaumenhaft, "America's First Nursing Textbooks," Nursing Outlook 37, no. 4 (1989): 185-186.

[9]National League of Nursing Education, "Essential Texts and Reference Books," AJN 32 (August 1932): 859-865; National League of Nursing Education, A Curriculum Guide for Schools of Nursing, 7th ed., (New York: National League of Nursing Education, 1932), 197-218.

(Volumes I-IV), and the Cumulative Index to Nursing Literature (CINL), 1956-1980 under headings of specific diseases, nursing care, nursing care studies, death, terminal illness, preoperative and postoperative nursing care, surgery and nursing, medical/medicine and nursing, maternity and nursing, labor and delivery, pediatric nursing, psychiatric nursing, and public health nursing. These headings changed from time to time or were different between the two indexes, so the search was slow. The journal sources were accessed primarily through use of bound volume and microfilm collections in the John Walter Scott Library at the University of Alberta. The principal journals used from this collection were:

The American Journal of Nursing, 1900-1980 (bound volumes and microfilm)

The Canadian Nurse and Hospital Review/The Canadian Nurse, 1905-1924 (microfilm); 1925-1980 (bound volumes and microfilm)

Nursing Times, 1963-1980 (bound volumes)

These journals were selected for their availability as well as their status as official organs of national nursing groups[10] with broad input from a variety of

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[10]Lavinia Dock, "Nurses' National Journals," British Journal of Nursing, 44 (January 1910): 542-545; Editorial, "Nursing Journalism - Forty Years," Trained Nurse and Hospital Review, 80 (June 1928): 758-59; H. Hanson, Professional Relationships of the Nurse, 2nd ed. (Philadelphia: W. B. Saunders, 1947), 22-31.

nurses as well as relatively high circulation rates compared to other journals during the time period.[11] In addition, some articles identified from early in the century were found in the Public Health Nurse Quarterly/Public Health Nurse (bound volumes).

Flexibility was needed in the design of this study, as it is in any historical research in order to locate and evaluate various important sources.[12] When the possible sources of early data identified in the Nursing Studies Index were accessed, it was found that they did not always reflect the type of article being sought. Many of the accounts were reports of institutions and government studies, although occasionally some case studies were included. A manual search of annual indexes of the American Journal of Nursing and Canadian Nurse and Hospital Review/Canadian Nurse was then undertaken volume by volume using the microfilms of the journals up to and including 1955[13] in order to locate suitable articles.

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[11]Nell Beeby, "The World's Nursing Journals," International Nursing Review, (July 1958): 63-67; Christine Reiman, "Comparative Statistics in Connection with Nursing Magazines of a National Character," International Nursing Review, (October 1928): 367-373.

[12]Janet Kerr, "Historical Nursing Research," in International Issues in Nursing Research, eds. Shirley Stinson and Janet Kerr, (London: Croom Helm, 1986): 32.

[13]After 1955, the search from the Cumulative Index to Nursing Literature was used as it provided a more complete listing of articles in nursing journals.

The indexes were searched for headings and articles with titles beginning with words such as: Nursing Care of..., Nursing Case Study, Management of..., Nursing Management of... and Case Study. A large number of articles were located in this way.

Access to early journal sources identified from the Nursing Studies Index at the beginning of the study as potentially useful to the study but unavailable in the collections at these libraries were sought by using the interlibrary loan service at the John Walter Scott Library. Funding to travel to Boston University to access the extensive holdings of early journals, such as Trained Nurse and Educator, The British Journal of Nursing, Nursing Times, The Nurse, and Pacific Coast Journal of Nursing, in the American Nurses Association library was not obtained. The University of Alberta library staff was very helpful in attempting to access photocopies of these journal articles through interlibrary loan, but success was mediocre at best. Turn around time for request, especially for articles from the British Journal of Nursing, was up to 9 months[14] and many requests remain unfilled. The librarian in Boston exercised her privilege

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[14]It should not be surprising that so few complete collections of early nursing journals exist as nursing schools in the first part of the century were notorious for their lack of books and resources, or even a library.

and declined to photocopy articles from the Trained Nurse and Hospital Review,[15] so many requests for articles from this journal were not even sent as this was the only place where they were held. Only the later microfilmed volumes of this journal under the name of Nursing World were located and brought in to supplement the incomplete collection here.

Passages from textbooks in which key words were found were photocopied. As the researcher lived at a distance of approximately 500 kilometres from the university during the first 7 months of the study, microfilms of the Canadian Nurse and Hospital Review/Canadian Nurse, American Journal of Nursing, and Nursing World were used to locate some of the data. The researcher would copy the appropriate passage on a word processor for those volumes available only on microfilm or make note of the source and exact location of the passage in the article so that the bound volume could be

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[15]Of interest to nurse historians is the fact that this was the first nursing journal in the United States, and possibly North America, with publication starting in 1888. The most complete collection was located in Boston, with other libraries on the continent only holding a few issues or volumes. The early volumes were apparently printed on newsprint and are at this point very fragile. Microfilms of the last few volumes of this journal (1955-60) are available but the early volumes have apparently never been microfilmed as they are not listed in any librarian reference guide to microfilms, and articles by many early nursing leaders are sadly deteriorating with the passage of time.

retrieved and photocopied during regular trips back to Edmonton. Other journals articles were read and photocopied at the University of Alberta after the researcher moved back to the city.

Passages from 17 textbooks and 621 journal articles in which comfort in nursing care was described were collected and used in the content analysis.

Data Analysis

Analysis centered on the identification of the parameters of comfort in different types of nursing care such as post-operative care, care of the chronically and terminally ill, pediatrics and maternity nursing in order to ascertain the role and significance of comfort to nursing in general. Analysis used both inductive and deductive approaches, similar to that used in grounded theory[16] in that analysis will begin before completion of the data collection and the researcher will move back and forth from the analysis to the data for verification. This study, however, did not make use of grounded theory methodology. Analysis took place on two levels, a content analysis and an analysis of comfort and the social context in which it occurred.

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[16]A. Strauss, Qualitative Analysis for Social Scientists, (Cambridge: Cambridge University Press, 1987), 11-14.

First Level of Analysis

Content analysis, as described in Field and Morse[17] was used to analyze the data collected from texts and journal articles in order to identify categories reflecting dimensions of comfort. Data collection continued until the categories became saturated. Saturation occurs when "no new information on the characteristics of the category is forthcoming."[18] In this study, saturation was deemed to have occurred when after exhaustive searching, no new categories or elements in the categories emerged.

Two copies of articles or pages containing passages with key words were made and key words coded using a yellow highlighter. The second copy was cut up, and the passages sorted into categories. This process started with the data from textbooks and articles from the early volumes of the Canadian Nurse. Each article or text was assigned a code number referring to the year of publication and for texts, the name of the author, for journal articles, an abbreviated journal title and a letter, to differentiate between several articles of the same year from the same journal. For example, the first

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[17]Peggy Ann Field and Janice Morse, Nursing Research: The Application of Qualitative Approaches (Rockville, Maryland: Aspen, 1985), 99, 103.

[18]Ibid., 111-12.

article from Canadian Nurse 1942 would be CN42A, the second article CN42B. This labelling avoided having to write out the full citation with each passage. The initial categories that had emerged and were labelled four months into the study were:

1. Denying comfort/minimizing discomfort or pain.
2. Arranging for the physical comfort of patients.
3. Arranging for the emotional/mental/psychological or psychosocial comfort of patients.
4. Comfort measures taken out through the direction of the patient.
5. Providing for patient comfort through a third (non professional) party.
6. Achieving comfort in spite of nursing actions.

As more data was collected from the Canadian Nurse and the American Journal of Nursing as well as a few articles which had come through interlibrary loan, three further categories were developed:

7. The ability of the nurse to fufill the role of comforter being contingent on physicians actions.
8. Comfort as a prerequisite for some other nursing goal.
9. Seeing to the little things/ seeing to the details.

These categories remained very fluid. Further data collection and analysis of the categories revealed two

threads emerging from the second category, in which comfort care was carried out for it's own sake and a second thread in which there was a second reason for giving care involving preventing complications, especially with later data. Evaluation of this brought up the possibility that there was a change occurring in the data which might in some way relate to the use of nursing aides after the second world war. Articles from Nursing World were searched as it was a journal for both registered nurses and licensed practical nurses. The passage of time and occurrence of events was emerging in the categories as some categories tended to have just data from later time periods. Therefore, addition to being sorted into categories, passages were organized within categories by decades and marked by a colored sticker with the code number on it. The cut passages were then grouped by decade and taped onto foolscap.

In addition to the importance of time in some categories, data for other categories, especially "comfort in spite of nursing actions" was difficult to find and the category was very far from saturation. Concentration on articles pertaining to so called difficult or uncooperative patients were sought in order to locate any available data on this.

After finishing the volumes of the Canadian Nurse and American Journal of Nursing and coding any

interlibrary loan articles that had come available, it was decided to pursue looking at the British literature available to see if any new categories emerged or if further data on difficult to saturate categories could be found. Using the search of CINL completed earlier, the last month of data collection was spent accessing appropriate articles from the bound volumes of Nursing Times and analyzing them for key words. No new categories emerged and only a small amount of data was found pertaining to difficult to fill categories. Data collection was brought to a close. Total time for data collection had taken approximately 10 months, about 3-4 months longer than originally anticipated. This was partly due to the slowness of the process of manually searching for appropriate article over such a long time period, the meticulous process of reading and searching for key words, as well as the delayed move of the investigator, leaving much of the work to be done at a distance with minimal access to the library.

Once all the final data was coded and sorted, categories were examined and resorted. The category "arranging for physical comfort" was split into the two threads and new categories were developed. One of these categories "comfort for comfort's sake" was expanded to include some of the data from "arranging for emotional comfort." The rest of the data on emotional comfort was

placed in a new category "emotional comfort techniques." Second level analysis began at the same time and final categories emerged:

1. Comfort as a prerequisite to a goal or an outcome.
2. Comfort for comfort's sake.
3. Comfort concurrent with other nursing goals.
4. Ability of the nurse to comfort contingent on physician orders/actions.
5. Delaying comfort.
6. Physical comfort through non-physical approaches.
7. Emotional comfort techniques.
8. Seeing to the details.
9. Patient directed comfort.
10. Providing comfort through a third person.
11. Comforting the family.
12. Failure to comfort.

A manifest content analysis,[19] in which tabulation of key words is undertaken and analyzed using descriptive statistics was not undertaken as the use of the key words, especially in later articles, was deemed to likely be dependent on the writing style of individual contributors to nursing literature.[20] Additionally, since

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[19]Field and Morse, Qualitative Research, 103.

[20]The possibility of substitution of other words for comfort in later years in discussed in Chapter 7.

the data was so rich, presentation of questionable statistics might have detracted from the presentation.

Second Level of Analysis

The second level of analysis looked at the data and identified categories in terms of the social, economic, and political context of the time in which they occurred. Such analysis is important in historical research in order to move beyond a chronological account of events.[21] The role and significance of comfort at different periods of time was assessed in light of different events such as changes in technology, type and location of employment of nurses, economic depression and changes in medical care. Synthesis of this information with the categories involved the selection, organization and analysis of the data which lead to writing of the exposition or narrative, the end result of historical research[22] presented in subsequent chapters.

The second level analysis actually began before the end of the first level analysis with the color coding of

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[21]O. Church, "Historiography in Nursing," Western Journal of Nursing Research, 9, no. 2 (1987): 276; B. Jennings, "Historical Research in Nursing," in Nursing Science Methods, ed. S. Gortner (University of California, 1987), 54.

[22]Teresa Christy, "The Methodology of Historical Research: A Brief Introduction," Nursing Research 24, no. 3 (1975): 192; L. Glass, "Historical Research," in Advanced Design in Nursing Research, eds. P. Brink and M. Wood (Newbing Park: Sage, 1989), 185 .

passages according to decade. This gave a rough visual overview of any emphasis in categories during any part of the time period. Once all of the data were coded and sorted, large sheets of paper, one for each category, were divided into columns of eight. Each column represented a decade and in these columns notes or summaries about each passage were made in pencil. This served two purposes. First, data in categories could be reviewed as a whole without shuffling through piles of foolscap sheets and, as well, organization of data within categories was made easier. Entries could be erased and moved into groupings.

The entries on these sheets were then analyzed and several streams emerged, with some of the categories relating to each other. The first three categories center on whether comfort was held to be a goal of nursing or a strategy used to achieve other goals. Categories four and five relate to treatment regimes, six and seven to emotional techniques, and ten and eleven to family involvement. Another element which emerged was the change in orientation from primarily physical comfort to the inclusion of emotional comfort overtime in some categories.

This change in physical-emotional orientation within categories was analyzed by making a time graph. This graph is represented in Fig. 1. Physical, physical-

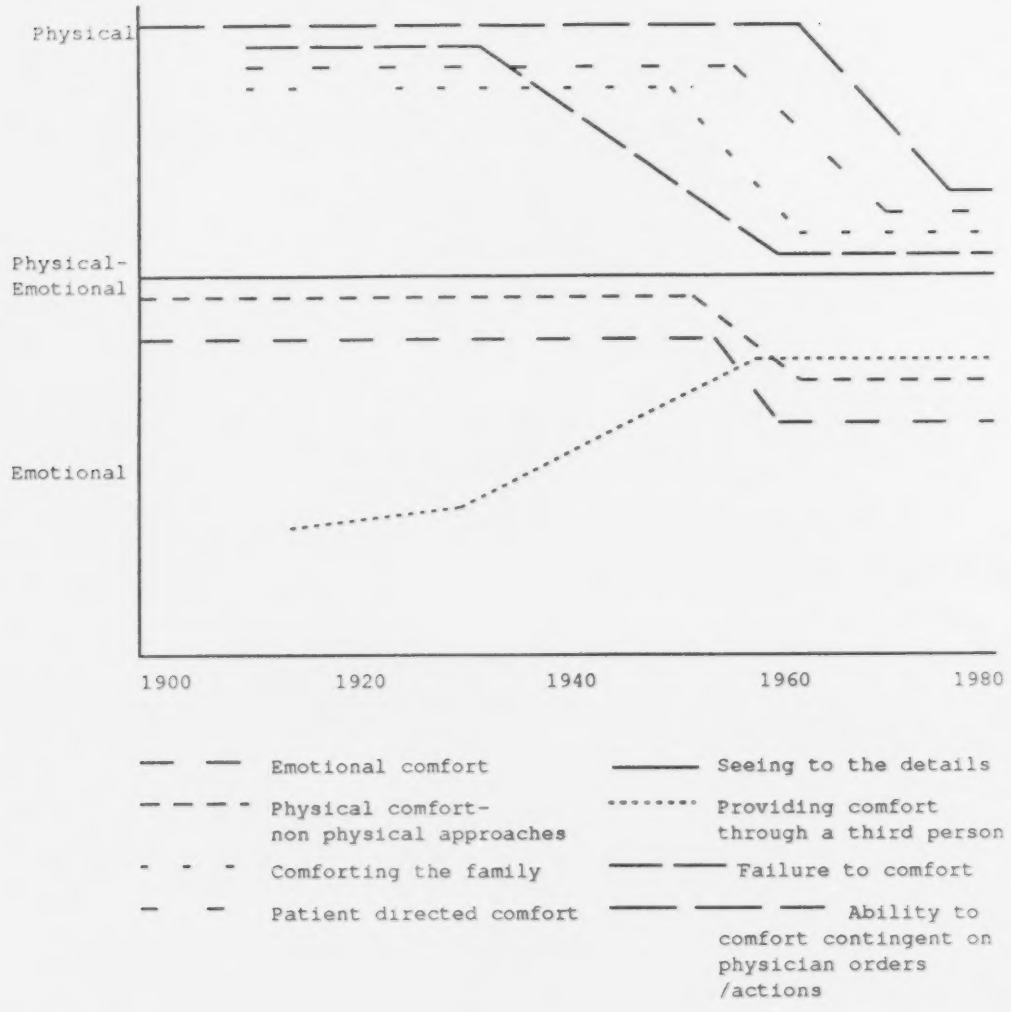

Fig. 1. Changes in emphasis on physical and emotional comfort in categories 1900-1980.

emotional and emotional comfort are on the vertical axis. The horizontal axis was a time line reflecting the whole of the period under study and various nursing, medicine, social, political and economic events which occurred were placed along this line. Both primary and secondary sources were used in constructing the time line.[23] From this time line, shifts in comfort could be visualized. The first major shift occurred around the 1930's and a second in the 1950's and 1960's. After once again reviewing the data in the categories, it was decided that three periods relating to comfort emerged. The first period from approximately 1900-1929 was relatively easy to determine from the graph. The end of the second period and beginning of the third was not so clear. However, several of the categories, specifically "seeing to the details" and "emotional comfort techniques" displayed quite a change in the way comfort was referred to or in techniques used to achieve comfort between the 1950's and the two decades following. From this it was determined that the second period should span 1930-1959 and 1960-1980.

These periods do not represent sudden changes in comfort but rather approximate periods in which changes were perceived based on analysis of the collected data.

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[23]Citations of sources for individual events are made in subsequent chapters.

There was no single cataclysmic event which changed nursing care, but rather combinations of events. The stock market crash of 1929 signalled the beginning of the depression and subsequent unemployment of nurses, but it was the combination of economic depression as well as influences from medicine which moved nurses slowly out of homes and into hospitals.

Reliability and Validity

External and internal criticism are the measures of validity and reliability in historical research. External criticism corresponds to validity in that the historiographer must establish whether or not the documents used are real or fraudulent through verification of authorship and document age.[24] Internal criticism refers to the reliability of evidence and focuses on what is stated in the documents.[25] The researcher, through "positive criticism"[26] must be sure to come to an understanding of what is being said in the document within the context of the time in which it is written. Additionally, the researcher should be aware of whether a document is a primary or secondary source. As well, reliability of evidence is established through the

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[24]Christy, Historical Research, part 2; Christy, "Historical Methodology", 190-191.

[25]Christy, Historical Research, part 2.

[26]Christy, "Historical Methodology", 191.

"tests of consistency and corroboration".[27] False, biased or inaccurate accounts are identified by checking one source against others. This process is referred to a "negative criticism" by Christy.[28] Fact is only established when two primary sources or one primary source and an uncontested secondary source are found. All other evidence is considered only probable or possible.[29]

In this study, books and journals from the John Walter Scott Library were considered as valid as far a date of publication and authorship. Copies of articles obtained through interlibrary loan from the collections of reputable libraries were also considered as valid, as were the several old textbooks obtained through private collections of known individuals.

Reliability, or internal criticism, was more difficult. As far as possible for the content analysis, primary source documents were used so that a first had account would be obtained. As stated before, primary sources of nursing care descriptions were those written by nurses who were involved with giving and overseeing direct nursing care. Suggestions for nursing care written by physicians were not included. The research attempted

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[27]J. Benjamin, A Student's Guide to History, 4th ed. (New York: St Martens Press, 1987), 8.

[28]Christy, "Historical Methodology," 191.

[29]Ibid., 192.

to come to an understanding of the contents of articles within the context of the time in which they were written. This included attempting to suppress any prejudice towards data espousing obedience and subordination of nurses, which was once demanded as normal and desirable, but now is seen in a different light. The researcher frequently used positive criticism to accept such elements in the data in light of the social times. The analysis depended to a great degree on the interpretation of the researcher. To ensure the accuracy of interpretation, many corroborating accounts were sought in order to check one against each other in developing the categories as well as in second level of analysis where secondary sources were used. When it came to some categories such as "failure to comfort" this was not easy as very few accounts were found of nursing care failures.

Limitations of the Study

The study was limited by the inexperience of the researcher. Glass[30] suggests that researcher involved in historical studies be experienced in the field. Since the researcher in this case was a graduate student, a nurse scholar with expertise in historical research was

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[30]Laurie Glass, "Historical Research," in Advanced Design in Nursing Research, P. Brink and M Wood eds. (Newbing Park: Sage, 1980), 199.

included on the thesis committee to guide the student in developing skills in historical research.

The study was also limited by the data. There is some inflexibility in the data as they already existed and were not generated by the researcher. Variables in historical research cannot be manipulated[31] and sources may be difficult to locate or may be incomplete.[32] In this study, some of the accounts of care were vague and the researcher could not go back and ask the writer to clarify what he or she had meant. There was also some difficulty in obtaining early accounts of nursing care, especially from British journals.

Historical research does not provide a single correct answer.[33] The conclusions drawn in this study were dependent on the assumptions and ability of the researcher and this raises concern of bias. Historical research is different from experimental research though and there may be several valuable interpretations of the same events by different researchers. This is one such interpretation of comfort.

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[31]Kerr, "Historical Nursing Research," 32.

[32]Christy, Historical Research, part 1; J. Lynaugh and S. Reverby, "Thoughts on the Nature of History," Nursing Research 36, no. 1 (1987): 4.

[33]Joan Lynaugh and Susan Reverby, "Thoughts on the Nature of History," Nursing Research, 36 (February 1987): 4.

Contribution of the Study

Since comfort, a traditionally important aspect of nursing care, remains abstract and is used in so many different ways in nursing literature, clarification is needed. This historical analysis assists in identification of dimensions of comfort used in the past. In coming to this understanding what comfort meant in the past, it's meaning today may begin to become clearer. Through this study, future researchers looking at comfort in the context of present day nursing care have a basis of understanding of how it had evolved.

CHAPTER 4

1900-1929: COMFORT AS NURSING'S FOCUS

In the early part of this century, comfort played a pivotal role in nursing care. Most of the data centered on physical comfort of the patient, emotional comfort playing only a minor role in nursing care. Little concerning comfort and the patient's family was found to be published as most care centered on the patient alone.

The Context

Characteristics of nursing practice during the period (Table 1) include the widespread employment of graduate nurses in private duty nursing. They were engaged to care for one patient in his or her own home for the course of the illness, which could last weeks.[1] This continued until the end of the 1920's when private duty nursing went into decline as access to increasing numbers of hospitals[2] improved and medical advances

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[1]P. Kalisch and B. Kalisch, The Advance of American Nursing (Boston: Little, Brown and Co., 1986), 219-221.

[2]Robert Dingwall, Anne Rafferty and Charles Webster, An Introduction to the Social History of Nursing, (London: Roultledge, 1988), 71-72; Kalisch and Kalisch, The Advance of American Nursing, 384; Paul Starr, The Social Transformation of American Medicine, (New York: Basic Books, Inc., 1982), 219.

TABLE I

SUMMARY OF CHARACTERISTICS OF PERIOD I: 1900-1929

NURSING

Education: Diploma based hospital programs with wide variation in quality of instruction and curriculum.

Employment: Graduates worked as private duty nurses in private homes. Hospitals staffed by students supervised by a few graduates. Students also sent out on private duty calls, fees retained by the hospital.

Relation to patient: 1:1 in private duty, students on wards most of day in hospital.

MEDICINE:

Little ability to cure. Most health care provided in patients homes.

SOCIAL/ECONOMIC:

World War I

Expansion of hospitals following the war.

heralded the decrease of contagious diseases such as typhoid fever, which the care of patients with had been a major source of employment for private duty nurses.[3] In the hospitals, student nurses gave most of the care,[4] spending most of their time on the wards as there were few classes.

As the delivery of nursing care was set up through the system of private duty and student dispense care, direct one to one contact between the nurse or student nu rse and the patient was frequent. Medicine had little ability to cure and the treatments prescribed for the nurse to carry out, such as baths, fomentations and massage, were time consuming. The nurse was expected to and had time to see to the comfort, primarily physical, of the patient. In the case of the private duty nurse, where she was hired on the request of the physician or family, seeing to the comfort of the patient might have had the added bonus of increasing her chances for continued as well as future employment:

> We like to think that the trained nurse in obstetrical practice has won her way over every competitor, but if it were so we would all become specialists in midwifery, since babies are born every minute and the demand for our service would be unending. Here among ourselves we may acknowledge that there are very many misguided mothers who still are not convinced

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[3]Kalisch and Kalisch, Advance, 383-384.

[4]Ibid., 384.

> that an exacting, expensive graduate is more to be desired that the experienced helper who tides over her patient with more comfort if with less science. Training will not take the place of sympathetic common-sense, and if we hold it over our rivals, it will be because, and only because, we make of ourselves from every possible stand-point a very present help in time of trouble.[5]

That certain elements of routine care could be provided less expensively by persons other than a registered nurse did not go unnoticed by others. As early as 1923 there was recognition that a subsidiary group could provide care such as bathing a patient and "keeping him comfortable in bed"[6] in minor illness. Private duty nursing was a fiercely competitive field.[7] In making the patients comfortable, nurses promoted their employment as the physicians who called them to a case would be satisfied their orders for rest were followed, while the family and patient would be satisfied by the comfort itself.

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[5]L. Adkins, "Care of an Obstetrical Patient," AJN 3 (June 1903): 709.

[6]J. Goldmark, Nursing and Nursing Education in the United States: Report of the Committee for the Study of Nursing Education (New York: MacMillan, 1923), 164.

[7]Not only did graduates in private duty have to compete with untrained "nurses", they had to compete with student nurses sent out on private duty assignments by their hospitals. The fees paid by families using student labor for private duty went to the hospital, not to the student. Kalisch and Kalisch, Advance, 184.

Categories of Comfort

Comfort as a Prerequisite to a Goal or an Outcome

General comfort of the patient, provided through nursing care, was seen to enhance recovery.[8] Comfort was the main goal of nursing as well as a major medical strategy to achieve the therapy of rest and outcome of recovery. Rest, through making the patient comfortable, was the held to be important to recovery in most cases.[9] Patient comfort, physical and mental, was equally important to the nurse as giving medications and treatments,[10] for it was through comfort the nurse helped

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[8]Albina Brodrick, "The Nursing of Children" AJN 44 (February 12, 1910): 125; Marion Parsons, "Some Points in the Nursing of a Fractured Femur in the Home" AJN 9 (November 1908): 104; Julia Sieke, "Care of the Patient Before, During, and After Anesthesia," AJN 21 (January 1921): 221.

[9]Katharine Amberson, "Nursing in Tuberculosis," AJN 27 (July 1927): 529; L. H. Beal, "The Nursing Care of Heart Diseases in the Acute Stages," AJN 27 (December 1927): 1008; Afina DeGraaf, "The Patient's Comfort" AJN 23 (December 1922): 185; Alice Gilman, "The Nursing of Nervous Diseases" AJN 16 (August 1916): 1081; A. Maxwell and A. Pope, Practical Nursing: A Textbook for Nurses, 3rd ed.(New York: G.P. Putnam's Sons, 1914), 180.

[10]A. Maxwell and A. Pope, Practical Nursing (New York: G.P. Putnam's Sons, 1907), 163; Maxwell and Pope, Practical Nursing, 3rd ed., 163; Amy Pope, Pope's Manual of Nursing Procedure, (New York: G. P. Putnam's Sons, 1919), 82.

the patient "reap the full benefit"[11] of the prescribed therapy.

Many of the strategies used by nurses to achieve comfort in order to enhance recovery were orientated to physical care. Making the patient comfortable in bed by adjusting covers, positioning with various pillows, pads, air rings, bedcradles and sandbags helped to induce sleep, as did alcohol rubs and tepid baths.[12] Comfort was maintained during treatment regimes through positioning and arranging bedclothes during a continuous surgical bath,[13] adjusting binders,[14] as well as modifying clothing,[15] and managing the physical environment through use of screens and mosquito netting[16] during fresh air treatment. Emotional comfort was also to be arranged through attention to environmental influences such as

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[11]Maxwell and Pope, Practical Nursing, 163; Maxwell and Pope, Practical Nursing, 3rd ed., 163.

[12]Beal, 1008-1009; Maxwell and Pope, Practical Nursing, 3rd ed., 165-167; Pope, Manual, 85-86; Isabel Hampton Robb, Nursing: Its Principles and Practice, 3rd ed.(Toronto: J. F. Hartz, Co., 1910), 527.

[13]Robb, Nursing, 154.

[14]Mary Farrall, "Obstetrical Nursing in Private Homes," Nurses' Journal of the Pacific Coast 7 (February 1911): 62.

[15]S. Smiley, "Care of Post Poliomyelitis Patients,: CN 25 (November 1929): 671.

[16]Stella Fewsmith and Louie Boyd, "The Nurse and the Tuberculosis Patient," AJN 9 (July 1909): 739.

light, draughts, noisy visitors, and household chores as well as by seeing to the patient's privacy and avoiding discussion of the patient's condition.[17]

Comfort was also used in the sense of being a nursing strategy prerequisite to achieving a another non-medical goal, such as the maintenance of normal functions like eating or for routine care. The nurse might position the mother before breast feeding,[18] bath and position and infant with meningitis before feeding,[19] clean the mouth and teeth of typhoid patients before meals,[20] or see that an infants bath water was at a comfortable temperature.[21] Other goals the nurse sought to achieve through making her patient physically or emotionally comfortable were gaining the patient's confidence[22] and, in the case of a public health nurse, making the patient more amenable to

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[17]Maxwell and Pope, Practical Nursing, 163-165; Maxwell and Pope, Practical Nursing 3rd ed, 163-165.

[18]K. DeWitt, "The Care of the Breasts in Obstetrical Cases," AJN 6 (April 1906): 433.

[19]Mary Jones, "The Nursing of Meningitis" AJN 3 (December 1902): 176.

[20]M. Ellis, "The Care of Typhoid Fever Patients" CN 3 (December, 1907): 635.

[21]L. Zabriskie, "Maternity Nursing in Hospital and Home," AJN 29 (October 1929): 1162.

[22]Margaret Purcell, "Nursing Care of the Insane" AJN 11 (March 1911): 431.

direction and the restraints of treatment to be taught.[23]

Comfort for Comfort's Sake

In this category, the nurses described nursing care given to provide comfort for the patient and did not articulate a further goal, thus implying that comfort was the end goal of nursing. A further goal might have been implicit in some of the data with the author having assumed that the reader would understand this, but it is not made clear. Aikens[24] suggested that the provision of comfort through measures not necessarily included in the physician's orders when no one was around to check up on the nurse, such as on night duty, tested the nurse's character and influenced her desirability as a nurse. The implication was that providing for patient comfort had a moral aspect in that it was a good thing to do. Measures to provide comfort for comfort's sake included applying binders,[25] loose, smooth clothes for infants,[26]

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[23]Edna Foley, "The Chief Points in the Field Nurse's Care of the Advanced Consumptive in his Home", Public Health Nurse Quarterly 1 (April 1915): 23.

[24]Charlotte Aikens, Studies in Ethics for Nurses (Philadelphia: W. B. Saunders Co., 1925), 114.

[25]W. Brerton, "Obstetrical Nursing," CNHR 8 (March 1912): 121; H. Corbin, "Suggestions for Care of the Breasts During Pregnancy," AJN 23 (April 1923): 547; E. Dickson, "The Care of Tuberculosis Children". CNHR 10 (December 1914): 775.

[26]Louella Adkins, "The Care of an Obstetrical Patient" AJN 3 (June 1903), 711; A.M.C. "Notes on the Nursing of Young Children," CNHR 10 (January 1914): 13.

positioning for surgery,[27] positioning with pillows,[28] as well as removing crumbs from the bed, attending to bandages, washing the patient, straightening sheets, rubbing back and limbs, subduing lights and maintaining proper ventilation and temperature.[29] Additionally ,the nurse was to enliven the spirits of patients and discourage visitors who might tire patients or cause infection in long term tuberculosis sanatoriums.[30] Most of this data reflects a preoccupation with physical care with the exception of the last article in which the emotional comfort of the patient is addressed.

Comfort is expressed a major end goal of nursing for cases where there is no medical therapy available, such as chronically insane patients[31] or in the case of a child with terminal meningitis.[32]

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[27]S. Clark, "Nursing Eye Patients" AJN 14 (January 1914):272.

[28]Charlotte Aikens, "Making the Patient Comfortable," CNHR 4 (September 1908):423; Aikens, Ethics, 113; Stella Goostray, "Nursing Care in Cerebrospinal Meningitis" AJN 27 (April 1927): 252.

[29]Aikens, "Making the Patient Comfortable", 423-424; Aikens, Ethics, 114.

[30]J. Kemp "The Nursing Care in Thoracoplastic Operations," AJN 29 (February 1929): 128-129.

[31]L. Laird, "Care of the Insane: ii. Nursing of the insane," AJN 2 (December 1901): 179.

[32]Grace Bradley, "A Hospital Incident" AJN 12 (June 1912): 715.

Comfort Concurrent with Other Nursing Goals

Some authors did not specifically identify comfort as the main goal for nursing but still suggested that it was an equally, if not more, important goal occurring concurrently with another goal. In one text, the prevention of bedsores was part of a chapter on patient comfort in which it was stated that "A bedsore, except in the rarest instances, proclaims poor nursing."[33] The quality of the nursing care was in part evaluated by the prevention of such occurrences and the ensuing comfort of the patient.

Other authors also discussed comfort in association with the positioning and skin care for the prevention of skin breakdown[34] as well as positioning and clothing to prevent of pneumonia,[35] cleanliness and compresses for the prevention or relief of infection,[36] positioning to

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[33]Minnie Goodnow, First-year Nursing (Philadelphia: W. b. Saunders Co., 1921), 117.

[34]Carrie Benham, "The Nursing of Rheumatism," AJN 24 (June 1924): 705; G. Breslin, "Obstetrical Nursing," CN 3 (April 1907): 195; DeWitt, "Obstetrical Cases", 434-435; Jones, "Nursing of Meningitis," 175; Parsons, "Fractured Femur," 110; Pope, Manual, 86.

[35]E. Ellis, "New Methods in Surgical Nursing," CN 5 (January 1909): 9; Pope, Manual, 86.

[36]Ellis, "Typhoid Fever," 634; Anna Jamme, "Some Recent Surgical Methods of the Present Day Surgical Nurse," AJN 9 (February 1909): 327; Martha Moore, "The Care of the Breasts and How to Increase Breast Milk,"

relieve dyspnea[37] and to favor the heart,[38] and frequent emptying of the bladder to prevent rupture.[39] In addition to comfort and the prevention or relief of various complications, comfort was occasionally addressed as concurrent with other goals such as protection[40] and safety[41] of the patient, manageability of an insane patient,[42] peace of a dying patient,[43] or teaching in the case of a visiting nurse.[44] When discussed with other nursing goals, comfort was often the focus of the writing or the goal mentioned first, as illustrated by these passages:

> It is highly desirable that the nurse caring for diseases of the joints should know their various manifestations and possibilities. It goes without saying that she must know how to secure her patient's immediate comfort, as

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AJN 14 (June 1914): 714.

[37]Jessie Catton, "Nursing in Pneumonia," AJN 3 (September 1903): 919-920; Jessie McCallum, "Simple Devices for the Comfort of Patients" AJN 4 (January 1904): 285.

[38]A. Spurr, "Vomiting- Clinical Observations and Treatment," AJN 10 (May 1910): 564.

[39]Brerton, "Obstetrical Nursing," 120.

[40]Clark, "Eye Patients," 272.

[41]Zabriskie, "Maternity Nursing," 1162-1163.

[42]Purcell, "Insane," 430.

[43]Robb, Nursing, 135.

[44]Mary Lent, "The True Function of the Tuberculosis Nurse," BJN 41 (November 7, 1908): 367.

> well as that of the future...Frequent baths give comfort and prevent the maceration of the skin and bedsores that may accompany the sweating.[45]

> A woman of this sort [an experienced nurse], when she has entered a home, includes in her care all of the patient's family, as well as himself. Of course, her attention is directed primarily toward the comfort and needs of the latter, but at the same time she instructs the family how to administer to those needs...[46]

Ability of the Nurse to Comfort Contingent on Physician Orders/Actions

The nurse, in addition to routine care such as hygiene and positioning, carried out various prescribed treatments order to make her patients comfortable and relieve pain. These included massage,[47] therapeutic baths,[48] poultices,[49] mustard packs,[50] hot or cold wet dressings,[51] fomentations,[52] wet and dry cups,[53] and

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[45]Benham, "Rheumatism," 704-705.

[46]Lent, "True Function," 367.

[47]H. Biermann, "Notes on Massage," AJN 7 (April 1907): 537; Kate Williams, "Method of Massage of the Scalp," AJN 2 (October 1901): 27.

[48]E. Simpson, "The Bath as a Healing Agent," AJN 3 (February 1903): 337; H. Turner, "Special Baths" BJN 35 (December 9, 1905): 473.

[49]E. Greene, "Nursing Renal Disease," CN 4 (October 1908): 471; Julia Schopfer, "Hints for Nursing in Yellow Fever," AJN 6 (January 1906): 230.

[50]E. Nora Nagle, "The Mustard Pack," AJN 25 (June 1925): 457.

[51]Ellis, "New Methods," 10; Alma Gault, "The Nursing Care of Erysipelas," AJN 26 (April 1926): 287.

enemas.[54] The choice of treatment was with the physician[55] and little written evidence of nurses disagreeing with or attempting to influence this choice was found. The exception is the following passage where the nurse would have favored an alternate treatment, but it is not known whether she voiced this to the physician or merely lamented the event in her writing:

> I remember a colored patient in the hospital whose breasts were very swollen and sore when the milk came in. Massage was ordered, and when one nurse was tired another was put on. Poor patient! I wonder how she stood it. Hot stupes would have been so much more comfortable![56]

Post operatively, physician control of comfort was also evident. The surgeon or resident controlled when the nurse could comfort the patient by such things as water.[57] As well, new treatments and routines affecting patient comfort originated with medicine:

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[52]Virginia Dryden, "Hydrotherapy," AJN 25 (August 1925): 655.

[53]Greene, "Renal Diseases," 471.

[54]G. Dwyer, "Nursing Care Following Operations on Spinal Cord and Brain," AJN 20 (May 1920): 614-615; Emma Long, "A Typhoid Case," AJN 13 (August 1913): 847-848.

[55]Gault, "Erysipelas," 287; Moore, "Care of the Breasts," 713.

[56]Moore, "Care of the Breasts," 713.

[57]Sieke, "Anesthesia," 226.

> The successful efforts of many of our eminent surgeons to modify the severity and to lessen the depressing effects of operations, and to bring about a more speedy and comfortable convalescence for their patients, has introduced many changes in the nursing of surgical cases.[58]

Medication, ordered by the physician, did not appear to be used to a great extent for comfort by nurses. Sedatives and narcotic analgesia were used to relieve pain[59] but often described as being given only for severe pain[60] with the suggestion made to use other medications for pain such as phenacetin, antipyrin, or ammonal before resorting to opium.[61] Few specific medications were available for the nurse to use for pain, other than something like nitroglycerin tablets or amyl nitrate for angina.[62] Nurses were expected to use narcotics to induce sleep only after attempts to make the patient comfortable through positioning, hot water bottles and massage had

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[58]Ellis, "New Methods," 7.

[59]E. Moynihan, "Acute Poliomyelitis," AJN 16 (September 1916): 1184.

[60]Brerton,"Obstetrical Nursing", 122-123; Laura Brighton, "Gastro-enterostomy," AJN 12 (July 1912): 793; G. Vandever, "Care and Management of Typhoid Fever," AJN 13 (August 1913): 845.

[61]A. Letham, "Rheumatism," AJN 5 (November 1904): 86.

[62]Beal, "Heart Diseases," 1009.

failed.[63] Good nursing was expected to make the patient comfortable and induce sleep without the use of medications.[64]

Some conditions involving severe pain were beyond the scope of the nurse and she was "helpless"[65] alone to deal with the situation. Her role then was to watch and report changes in her patients to the physician.[66]

Delaying Comfort

This category was again orientated towards physical care of patients rather than emotional. Nurses occasionally had to carry out treatments which were not comfortable for the patient. In some of these, the pain and discomfort of treatment and care was seen as unavoidable.[67] The nurse did not express any action to minimize the discomfort but might encourage the patient

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[63]Maxwell and Pope, Practical Nursing, 3d ed., 181.

[64]C. Fleming, "The Nursing of the Mentally Sick," CN 25 (February 1929): 86.

[65]Vandever, "Typhoid Fever," 845.

[66]Breslin, "Obstetrical Nursing," 195; Clark, "Eye Patients," 272; E. Flanagan, "The Nursing of Typhoid Fever," CN 24 (November 1928): 573; Vandever, "Typhoid Fever," 845.

[67]Amberson, "Nursing in Tuberculosis," 533; Bierman, "Massage", 537; S. Kenny, "Erysipelas: A Few Observations," AJN 12 (September 1908: 978; Parsons, "Fractured Femur", 104, 110; T. Peter, "On Hysteria From a Nursing Point of View," British Journal of Nursing 36 (June 1906): 434.

to put up with it[68] or just leave the patient to get used to it:

> After a week, a specially-designed binder is worn, strapped very tightly to the chest. At first this is a source of great discomfort to the patient,but after becoming accustomed to it, he usually wears it even when sleeping.[69]

Many times the nurse did try to minimize the discomfort of a treatment by patience and gentleness during the treatment,[70] adjusting covers,[71] massage,[72] adjusting technique or using correct technique.[73] Nurses also tried to minimize discomfort following invasive medical interventions by massage and rubbing,[74] using vinegar inhalations and warm water to induce vomiting of mucus in post operative nausea,[75] and supporting the

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[68]Parsons, "Fractured Femur", 110.

[69]Amberson, "Tuberculosis", 533.

[70]De Witt, "Obstetrical Cases", 432; Letham, "Rheumatism", 87; Parsons, "Fractured Femur", 108; Edna Swartz, "Infantile Paralysis," AJN 12 (July 1912): 792.

[71]E. Lewis, "Nursing Typhoid Fever," AJN 14 (November 1913): 104; Grace Knight, "Some of the Newer Methods of Medical Nursing," AJN 9 (March 1909): 403.

[72]Nagle, "Mustard Pack", 457.

[73]Jamme, "Surgical Methods", 325; M. Parker, "Enemas," CN 23 (April 1927): 180; Kate Williams, "Massage for Constipation," AJN 1 (July 1901): 715.

[74]Laura Hartwell, "Tuberculosis Nursing," The Nurse, 6 (June 1917): 423.

[75]Aikins, "Comfortable", 423.

patient's chest when coughing occurred after chest surgery.[76]

Physical Comfort Through Non-Physical Approaches

Physical comfort and relief of pain was dealt with mainly through physical measures. Attempts to use a non-physical approach were limited to expressions of sympathy[77] or firm sympathy and assurance that the pain would decrease.[78] One nurse suggested letting patients with terminal or chronic pain know medications were coming at a certain time in order to decrease worry,[79] an idea to be echoed more frequently in the future. Patient teaching in respect of comfort was limited to breast feeding[80] and infant care.[81]

Emotional Comfort Techniques

Diversion and the attitude and manner of the nurse were important in seeing to what was then referred to as

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[76]Kemp, "Thoracoplastic Operations," 128.

[77]Elizabeth Hanson, "The Personal and Impersonal Nurse," AJN 16 (February, 1916): 404.

[78]DeGraaf, "Comfort," 185.

[79]Mildred Constantine, "Nursing Care of Chronic Diseases," AJN 27 (June 1927): 436.

[80]De Witt, "Obstetrical Cases," 433; Anna Schmitz, "The Feeding of Mothers in Confinement," AJN 5 (March 1904): 371.

[81]H. Churchill, "Baby Hygiene Nursing," CNHR 13 (July 1917): 357.

the mental comfort of patients. The nurse could divert the patient's attention,[82] show pictures of familiar scenes,[83] or perhaps leave the melancholic patient alone as amusements were considered "painful"[84] in this instance. She was to be tactful in ascertaining the cause of a patient's worry and report it, but to avoid discussing their condition[85], to display a "nonpessimistic"[86] attitude, to inspire hope and confidence through a sincere wish to help, firm belief in recovery, and a silent sympathetic attitude[87]. Private duty nurses might be expected to undertake some household chores or avoid friction with servants in order to save the patient worry[88]. Physical care such as skin care and massage were also seen to enhance emotional as well as

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[82]Sieke, "Anesthesia," 221.

[83]M. Shepperson, "The Care of Nervous Patients," AJN 6 (January 1906): 238.

[84]Laird, "Care of the Insane," 174.

[85]Maxwell and Pope, Practical Nursing, 3d ed., 163-5.

[86]Dickson, "The Care of Tuberculosis Children," 775.

[87]DeGraaf, "Comfort," 185.

[88]Maxwell and Pope, Practical Nursing, 3d ed., 164.

physical comfort[89] and by making the patient think he was getting better:

> Emaciated patients often find comfort in an oil rub following the alcohol rub. The rubbing is soothing and creates a good mental impression, causing the patient to think he is increasing in weight, which is a favorable symptom.[90]

Nurses did not deal directly with the patient's concerns about his or her illness but rather avoided such contact and instead approached emotional comfort through having the patient not worry and avoid brooding.

Seeing to the Details

> ...there is nothing concerns the comfort of the patient that is small enough for her [the nurse] to be careless about...the comfort of the patient is her first and last consideration.[91]

Seeing to the details of comfort was an expectation placed on the nurse.[92] She was in close proximity to her patients and had time to fuss over details. Details of care were referred to as "little things"[93] or special

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[89]Elizabeth Gordon, "Some Observations on the Nursing of Typhoid Fever," AJN 3 (May 1903): 594; Robb, Nursing, 53.

[90]Fewsmith and Boyd, "Tuberculosis," 741.

[91]Aikens, "Comfortable," 422.

[92]Ellis, "Typhoid Fever", 634.

[93]Maxwell and Pope, Practical Nursing, 164; Pope, Manual, 83; Sieke, "Anesthesia," 221; Bertha Smith, "Convalescent Nursing," AJN 4 (September 1904), 931.

points,[94] and involved daily bathing, clean linen, adjusting the environment through lighting and temperature as well as avoiding exposure of the patient, finding out what was worrying the patients, and never leaning on beds or rocking in rooms. The entertainment of convalescent patients was also something which added to the patient's comfort and the value of the nurses' service to that patient.[95]

Patient Directed Comfort

Little data was found from this time period about patients participating in their own care. It was limited to late in the period with an instance of the patient assuming the position most comfortable to him[96] and recognizing the chronically ill patient as knowledgable and able to direct his own comfort.[97]

Providing for Patient Comfort Through a Third Person

Nurses in the early time period rarely used a third person to provide comfort to their patients. It was limited to some informal patient to patient contact:

> The nurse, trying in a kindly way to ascertain the cause of her distress, learns that she has

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[94]Goodnow, First Year Nursing, 118.

[95]Smith, "Convalescent Nursing," 931.

[96]Benham, "Rheumatism," 705.

[97]Constantine, "Chronic Diseases," 435.

> not slept for three nights, ever since her physician at home had told her that she must come to the hospital for an operation...She was much comforted, however, when she heard that her bed would be next to someone who had a similar operation, and by the time she was ready to go to the ward her tears had all vanished and hopeful lines had replaced worried wrinkles.[98]

The lack of attention to the use of others, such as family members and clergy, to provide comfort for the patient might have been because the patient was most often cared for in the home. The nurse probably had little to do with arranging for visits from the clergy, more likely a family responsibility. She was paid by the family to provide care and comfort for the patient and therefore it would not have been considered proper in many cases for her ask or expect the family to help. The nurse who expected the family members to provide for the patient's comfort might not find herself employed for long.

Comforting the Family

Reference to comfort of the family was rare. The nurse of this period was focused for the most part on care of the patient, not the family, and it was only indirectly through care of the patient that the family

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[98]Hanson, "Personal", 405.

was comforted.[99]

Failure to Comfort

Only one instance of failure to comfort was found to be described in data from this period, it being case where nurses had carried out the doctor's order to massage engorged breasts when hot stupes would have been less painful[100] previously discussed. Nurses had patient comfort as their primary goal at this time and to have the patient develop such things as decubitus ulcers and other discomforts was believed to be a sign of poor nursing. It might be that nurses did not write of their failures or perhaps that editors chose not to publish accounts of poor nursing care.

Comfort in Nursing Care

1900-1929

Comfort was the major goal of nursing care, used to achieve the medical treatment of rest, in acute or convalescent patients. In other words, patient comfort was a goal of nursing as well as a strategy of medicine. For patients for whom no medical therapy is available, such as terminal cases and chronically insane, comfort is the also the major goal of nursing (Fig. 2). When in

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[99]Adkins, "Obstetrical," 711; Jones, "Meningitis," 179.

[100]Moore, "Care of the Breasts," 713.

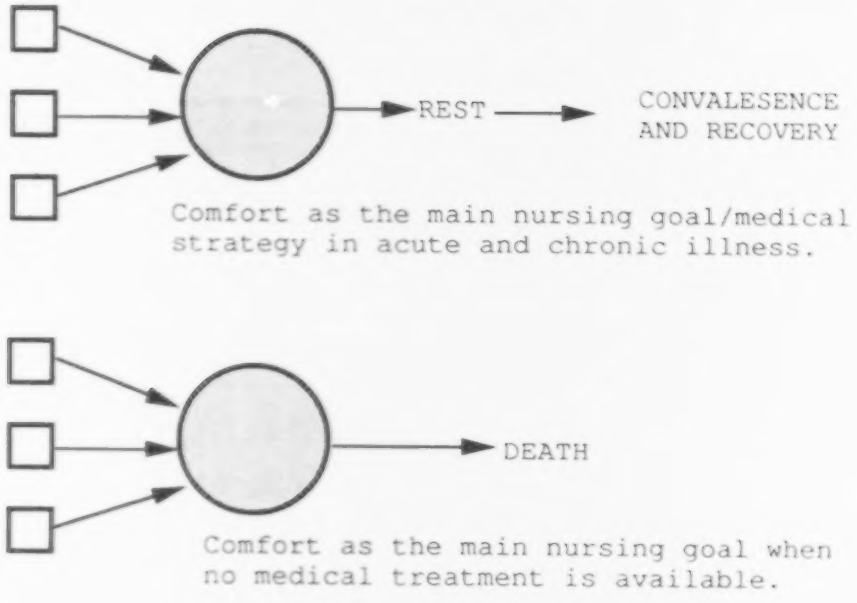

Fig. 2. Main roles of comfort in nursing care identified in Period 1 (1900-1929): open squares, nursing strategies; shaded circles, comfort as a nursing goal.

combination with other goals, comfort was still of prime importance. Taxonomies of nursing strategies (Fig. 3 and Fig. 4) constructed from the content analysis data show that patient comfort was centered on physical care for the most part. Non physical strategies were focused on the attitude and manner portrayed by the nurse, diversion of the patient away from concerns about his or her illness, and very occasionally, indirect family and patient to patient comfort.

Comfort during this time period was the focus of nursing because it was a morally good thing to and it was the was the way to achieve the prime medical therapy of rest. Comfort also played a role in securing continued employment for the private duty nurse who relied on the satisfaction of the physician and patient's family for referrals and future calls.

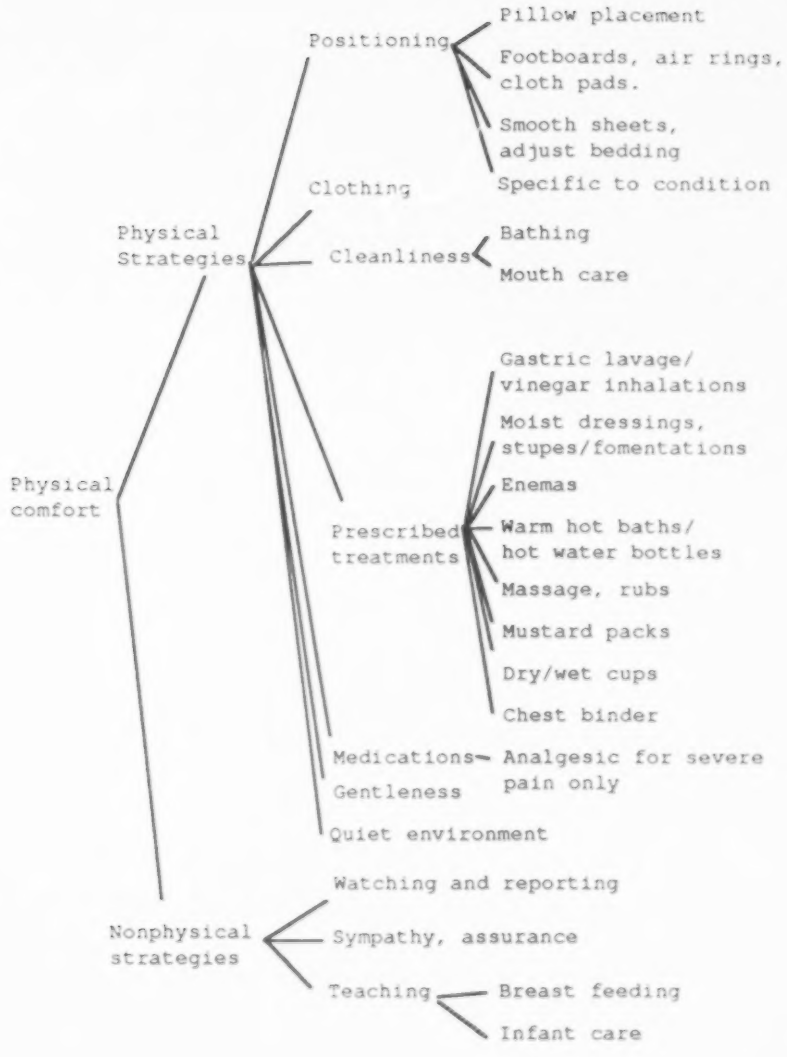

Fig. 3. Taxonomy of physical comfort strategies 1900-1929.

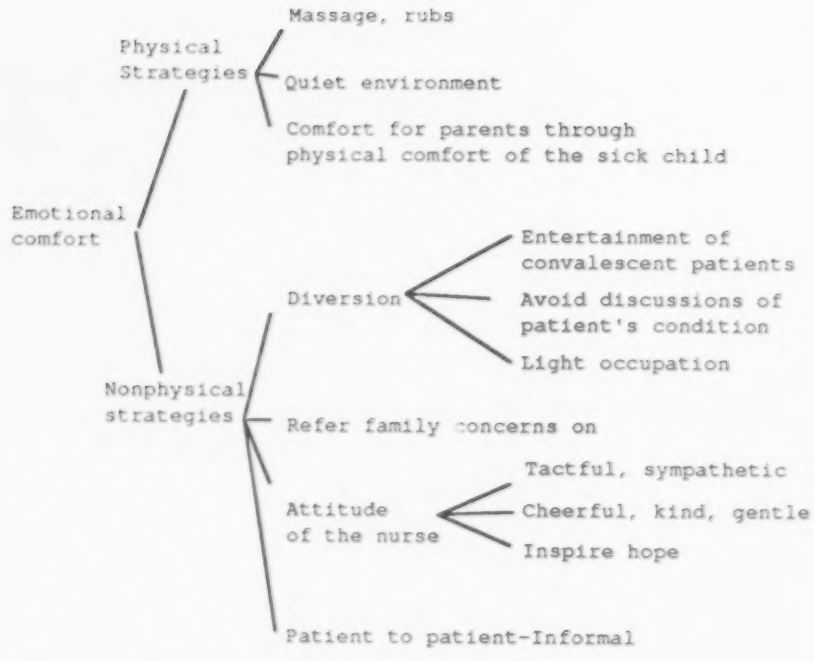

Fig. 4. Taxonomy of emotional comfort strategies 1900-1929.

CHAPTER 5

1930-1959: COMFORT IN TRANSITION

During the middle of the time under study, there were many changes in the health care system, as there were in society as a whole. These changes had resounding effects upon nursing. Some of these changes can be seen in the shift away from comfort as the focus of nursing.

The Context

Nurses experienced widespread unemployment in the 1930's as during the depression few families could afford to hire private duty nurses.[1] By the 1940's and the second world war, there was a shortage of nurses[2] and in order to provide care, use of assistant nurses and auxiliary workers became entrenched in the hospital systems of the United States, Canada and Great Britain[3].

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[1]J. Coburn, " "I See and am Silent": A Short History of Nursing in Ontario," in Women and Work: Ontario 1850-1930, ed. J. Acton, P. Goldsmith, and B. Shepard (Toronto: Canadian Women's Educational Press, 1974), 146.

[2]Canadian Nurses' Association, The Leaf and the Lamp (Ottawa: Canadian Nurses' Association, 1968), 88.

[3]P. Kalisch and B. Kalisch, The Advance of American Nursing, 2d ed. (Boston: Little, Brown Co., 1986), 588-590; M. Street, Canadian Nursing in

Student nurses continued to provide a large percentage of care as well.[4] By the 1950's the relationship of the registered nurse to the patient had changed from a one-to-one direct care situation to one in which her prime responsibilities involved "administration..., supervision of workers...,and provision of comprehensive nursing services."[5] Nursing care came to be seen as being composed of hierarchial functions differentiated as simple, intermediate and complex[6] or basic and technical.[7] Basic care included physical comfort through bathing, positioning and assistance with elimination.[8]

Employment of nurses shifted from private duty to general duty on hospital wards due, by and large, to the economic situation of the depression. (Table II) As well,

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Perspective: Past, Present and Future. Keynote address at the 50th Anniversary of the University of Alberta Hospital and the University of Alberta Schools of Nursing. (Edmonton: University of Alberta, 1974), 11; Rosemary White, The Effects of the National Health Service on the Nursing Profession 1948-1961 (London: King Edward's Hospital Fund for London, 1985), p. 14.

[4]H. Goddard, The Work of Nurses in Hospital Wards: Report of a Job-Analysis, (London: Nuffield Provincial Hospitals Trust, 1953), 134.

[5]Kalisch and Kalisch, The Advance of American Nursing, 589.

[6]M. Montag and R. McManus, The Education of Nursing Technicians, (New York: G. P. Putnam, 1951).

[7]H. Goddard, The Work of Nurses, 28-37.

[8]Ibid., 28-29.

TABLE II

SUMMARY OF CHARACTERISTICS OF PERIOD II: 1930-1959

NURSING

Education: Predominantly diploma, hospital apprentice type programs. Increase in attention to psychological aspects of care in curriculum as time progressed.

Employment: Private duty in patient's homes (early)
Institutional as staff nurses (later)

Relation to patient:
1:1 (early)
Nurse-Aide/Student-Patient (later)

MEDICINE

Increased ability to cure as antibiotics, new equipment, and new surgical techniques available.
Hospitalization required for treatment.
Rehabilitation introduced.

SOCIAL/ECONOMIC

Depression (early) Little ability to pay for health care.
World War II (mid-period) Impetus for mass production of penicillin.

with new medical treatments in the form of antibiotic therapy and surgery,[9] developed as a result of war needs, care could be more efficiently carried out in the expanded hospital system. New medical treatments decreased the need for "prolonged bedrest or nursing care"[10] and numerous local applications and procedures carried out or assisted by nurses.[11] The concept of rehabilitation was being introduced in medicine.[12] Care in the home was no longer feasible or even desired, especially by the medical profession.[13] Starr suggests that in the United States, the shift to institutional employment occurred as physicians gained control of the hospital system and needed compliant subordinates to

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[9]Robert Dingwall, Anne Rafferty and Charles Webster, An Introduction to the Social History of Nursing, (London: Routledge, 1988), 71-72; Edward Shorter, The Health Century (New York: Doubleday, 1987), 4-6.

[10]V. Coleman, The Story of Medicine (London: Robert Hale Ltd., 1985): 210.

[11]L. Allen, "The Sulphonimides: Nursing Care of Patients Receiving Sulphonimides," AJN 42 (February 1942): 144-145.

[12]C. Emerson and J. Bragdon, Essentials of Medicine 18th ed. (Philadelphia: J. B. Lippencott, 1959), quoted in B. Bycroft, "Rehabilitation," CN 58 (August, 1962), 697.

[13]Starr discusses the idea that it was to the advantage of physicians to have their patients in hospital as the could look after more patients and maximize their incomes at the same time in this manner. See Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, Inc., 1982) 219.

carry out their orders[14]. Although private duty was not easy, nurses did not readily gave up their status as independent practitioners and institutional employment was resisted, although finally economic pressures forced nurses to accept hospital positions[15].

Movement to reform nursing and nursing education was marked by major reports on nursing education - the Goldmark Report[16] in the United States, the Weir Report[17]

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[14]Starr, Social Transformation, 220-221.

[15]Indepth analysis of the shift of nursing from independent private duty to the status of hospital employee has been undertaken by U.S. and Canadian scholars. See David Wagner, "The Proletarianization of Nursing in the United States," International Journal of Health Services, 10, no. 2 (1980): 271-290 and David Coburn, "The Development of Canadian Nursing: Professionalization and Proletarianization," International Journal of Health Services, 18, no. 3 (1988): 437-456.

[16]Although this report was authored in the period discussed in the previous chapter, attempts to put into place recommendations for improvements through better instruction and improved curriculum were ongoing in the 1930's. J. Goldmark, Nursing and Nursing Education in the United States: Report of the Committee for the Study of Nursing Education (New York: MacMillan, 1923).

[17]It was recommended in this report to remove authority for nursing education from the hospitals and place it under the auspices of post-secondary institutions, a move which only began to occur in Canada several decades later. Additionally, specific recommendations to include courses on psychology where made. G. M. Weir, Survey of Nursing Education in Canada (Toronto: University of Toronto Press, 1932).

in Canada, and the Harder Report in Great Britain.[18] One of the changes that was called for in nursing education was the inclusion of courses on mental hygiene and psychiatric nursing in nursing education programs.[19] Prior to 1935, almost half of American nursing schools provided "no preparation in nervous and mental diseases."[20] Near the end of the period, the integration of psychological aspects of care in nursing curriculum is in evidence.[21]

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[18]The Harder Report was commissioned by the British government after the second world war. It affirmed that auxilliary nurses, or SEN's, were necessary to the delivery of nursing care, thus reinforcing the division of nursing care and nursing education into hierarchial levels. White, The Effects of the National Health Service, 13-14.

[19]Esther L. Brown, "Nursing as a Profession" (New York: Russell Sage Foundation, 1936): 35; Esther L. Brown, Nursing for the Future Report prepared for the National Nursing Council (New York: Russell Sage Foundation, 1948): 86-89.

[20]American Nurses' Association, Some Facts About Nursing, (New York: American Nurses's Association, 1935), 29; cited in Brown, Nursing as a Profession, 35.

[21]The work of Hildegard Peplau, a psychiatric nurse and instructor in nursing education at Teacher's College, Columbia University articulated the importance of psychological aspects of care and the nurse patient relationship. Her work on nurse patient relationships was adopted into nursing care extensively, as will be seen in the next chapter. See Hildegard Peplau, Interpersonal Relations in Nursing (New York: G.P. Putnam's, 1952).

Categories of Comfort

Comfort as Prerequisite to a Goal or an Outcome

Comfort, especially early in the period, remained to some the major goal of nursing, on which the medical therapy of rest, and subsequent recovery hinged.[22] This was especially so for such patients as those with cardiac conditions in which:

> The ultimate aim in nursing care of a cardiac patient should be the greatest possible degree of comfort, for without comfort there can be no rest.[23]

In order to achieve comfort and subsequent rest, the nurse was "the policeman...when it comes to enforcing

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[22]Lucia Allyn and Josephine Steiner, "Nursing Care in Malaria," AJN 46 (October 1946): 675; Regina Boylan, "Thoracic Surgery," The Pacific Coast Journal of Nursing, 26 (March 1930): 140-141; Clara Demko, "Staphylococcal Pneumonia," CN 52 (December, 1956): 972; R. Jones, "A Case Study: Mitral Stenosis with Auricular Fibrillation," AJN 38 (October, 1938): 1153; R. Keppy, "Treatment of Congestive Heart Failure," CN 45, no. 8 (1949): 580-581; J. Montemeuro, "Arthritis," CN 42 (March 1946): 225; R. Olson, "The Treatment and Nursing Care of Chorea," AJN 34 (June 1934): 530-532; L. Sommermeyer, "Acute Pancreatitis," AJN 35 (December 1935): 1161; Anna Taylor, "Comforts for Cardiac Patients," AJN 38 (July 1938): 769; Anna Taylor, "Physical Comforts," AJN 42 (February 1942): 157; Elgie Wallinger, "Heart Disease in Children," AJN 40 (January 1940): 9-10; E. Wilcox, "Rheumatic Fever: Diagnosis, Prognosis, Treatment and Nursing Care," AJN 45 (February 1945): 98; Clara Yoder, "Nursing Care in Scarlet Fever," 41 (February 1941): 145.

[23]Jones, "Mitral Stenosis," 1154.

rest periods"[24] and had to "think and act for her patient"[25] seeing to physical comfort through positioning with various pillows, footboards and sandbags, mouth care, regulating food intake, monitoring bowel movements and urinary output, and mental comfort by maintaining the patient's personal appearance and relieving the patient of the responsibility of the illness.

Others began to refer to comfort more in the sense that it was an important strategy in working towards goals other than rest. Physical comfort was important in the success of prescribed treatments such as oxygen[26], cast care[27], chest aspiration[28], blood transfusion[29], intravenous fluids[30], sulfonamide administration[31] and

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[24]Montemeuro, "Arthritis," 225.

[25]Taylor, "Cardiac Patients," 768.

[26]Sister Mary Doris, "Glomerulonephritis," CN 52 (September 1956): 713; M. McLellan, "Rheumatic Heart Disease," CN 47 (July 1951): 517; L. Olson, "Oxygen Therapy," AJN 33 (March 1933): 195.

[27]L. Allen, "Congenital Dislocation of the Hip," AJN 47 (November 1947): 723.

[28]Ida MacDonald, "Nursing Care in Empyema Thoracis," AJN 41 (February 1941): 179.

[29]A. Hartley, "Nursing Care in Blood Transfusion," AJN 40 (March 1940): 249-250; E. Wilms, "Banti's Disease," CN 46, no. 1 (1950): 60.

[30]E. Hlohinec, "Nursing Care in Nephritis," AJN 48 (November 1948): 690; A. Hunter, "Surgical Nursing Care in Thyroid Intoxication," CN 29, no. 10 (1933): 534.

fresh air. [32] Physical comfort contributed to keeping a patient cheerful[33] and, later in the period, to the reassurance of his or her family.[34] Comfort through positioning was prerequisite to assisting breast feeding[35], and position, cleanliness and warmth were eating, elimination or sleep[36] comforting and reassuring a crying child prior to feeding.[37] Relief of pain was

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[31]L. Bailey, " Nursing Care During Chemotherapy," CN 38, no. 11 (1942): 837; Hendrika Vandershuur, "Nursing Care of Patients Receiving Sulfonimides," AJN 45 (January, 1945): 39.

[32]Abby Choate, "Nursing Care of Patients with Whooping Cough," AJN 35 (November 1935): 1033-1034.

[33]N. Jamieson, "Nursing Care in Scarlet Fever," CN 31 (January 1935): 17.

[34]Brenda Carter, Nancy Franklin and Betty Woolner, "Trends in Pediatric Nursing," CN 48 (September 1952): 701; J. Colt, "Care of the Patient with an Aortic Graft," Nursing World 127 (February 1953): 13.

[35]Lillie Kirkes, "Hints on Helping Mothers," AJN 59 (December 1959): 1741.

[36]Beryl Arensberg, "Loving Care Does the Trick," AJN 56 (May 1956): 623; Janet Brown, "New Concepts in Geriatric Nursing," CN 53 (April 1957): 290-291: L. Dignan, "The Nursing Care of Mental Patients," CN 37, no.2 (1941): 86; R. Gilbert, "Maternity and Mental Hygiene: Some Considerations for the Public Health Nurse," Public Health Nursing 29, no.2 (1937): 90; M. Gorey, "Nursing Care for the Spastic Child," AJN 39 (April 1939): 369; Clarice Hargiss, " When Nurses Know the Patient--," AJN 47 (December 1947): 831; M. Kerr, "Nursing Responsibilities in Cerebral Palsy," AJN 46 (July 1946): 471; Muriel McClure, "When She Choses Breast Feeding," AJN 57 (August 1957): 1002.

[37]K. MacLennan, "Nursing Care in Whooping Cough" CN 34, no. 3 (1938): 129.

necessary before the establishment of "friendly relations"[38] between the nurse and patient and patient teaching sometimes commenced after a patient was made comfortable.[39] Emotional comfort was a key strategy for psychological adjustment to illness[40] to improve the mental attitude[41] and a combination of physical and mental comfort helped with patient confidence and cooperation[42], rehabilitation[43] or the achievement of efficient care[44]. Harmer, early in this time period named

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[38]C. Cover, "Eye Surgery: The Patient and the Nurse," AJN 39 (May 1939): 499.

[39]Joanne Hughes, "Nursing Care After Intramedullary Nailing," AJN (February 1959): 240.

[40]G. Adams, "Nursing Aspects of Epidermoid Carcinoma," CN 40, no. 8 (1944): 580.

[41]Myrl Peterson, "Nursing Care of the Thyroid Patient," AJN 40 July (1940): 780.

[42]Carole Eldridge, "Peptic Ulcer," CN 55 (February 1959): 118; C. Harvie, "Corpus Luteal Hemorrhage Surgery and Nursing Care," CN 46, no. 11 (1950): 914; E. Holmquist, " The Patient with a Trophic Arthritis," AJN 49 (May 1949): 303; Edna Scanlon, "Nursing Care in Viral Hepatitis," Nursing World 127, no.1, (1953): 12; M. Tracy, Nursing: An Art and a Science (St. Louis: C.V. Mosby, 1938), 63; Lily Watanabe "Epidermoid Carcinoma," CN 52 (July 1956): 535.

[43]Elizabeth Morgan, "A Push, Anyone?" AJN 58 (June 1958): 831; Dorothy Tollefson, "Nursing Care of the Patient with an Ileac Diversion of the Urine," AJN 59 (April 1959): 536.

[44]Sarah Alexander, "Nursing Care of a Patient After Breast Surgery," AJN 57 (December 1957): 1571; Anna Prochazka, "Nursing Care in Hemiplegia," AJN 46 (February 1946): 118.

the three fundamental aspects of nursing as maintenance of health and health teaching, prevention of disease and cure of disease[45]. Comfort, physical and mental, was the main nursing strategy used with ill patients to achieve these fundamental aspects as shown by the introduction to chapter on comfort in the 1931 edition of her textbook:

> From the time the patient is duly admitted to the ward, to make him as comfortable as possible in mind and body is one of the first and most important factors in nursing care. His recovery will depend to a large extent upon his comfort, and this will depend almost entirely on the nursing care.[46]

This theme of comfort as the main strategy was not continued in the later editions of the text. The chapter on comfort was no longer included in the 1939 and 1955 editions revised by Virginia Henderson.[47] Comfort remained one of many strategies or functions of the nurse[48], but not necessarily the key one, used to move the patient toward recovery.

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[45]Bertha Harmer, Textbook of the Principles and Practice of Nursing 2d ed. (New York: MacMillan, 1931), v.

[46]Ibid., 63.

[47]Bertha Harmer and Virginia Henderson, Textbook of the Principles and Practice of Nursing 4th ed.(New York: MacMillan Co., 1939); Bertha Harmer and Virginia Henderson, Textbook of the Principles and Practice of Nursing 5th ed (New York: MacMillan Co., 1955).

[48]Eva Brackenridge,"Combined Surgical and Medical Nursing," CN 49, (November 1953): 851; Harmer and Henderson, Principles and Practice 4th ed., 6; Harmer and Henderson, Principles and Practice 5th ed., 152.

Comfort for Comfort's Sake

For patients with medically untreatable conditions, comfort was still seen as a goal of nursing[49] and sometimes the only goal left:

> Medicine has little to offer them, and the nurse can only hope to make them as comfortable as possible during the course of their usually fatal disease.[50]

> One step further brings us to the hardest cases our nurses are asked to care for- fractured spines in which the cord injury is so complete that recovery is very remote, and in most cases impossible...generally the nurse's chief duty is to make the patient as comfortable as possible, both physically and mentally, knowing at the same time that nothing more can be hoped for.[51]

Emphasis on physical comfort for comfort's sake was evident in care given to a wide variety of non-terminal patients as well. After treatment[52] or delivery[53] and before she left a patient[54] the nurse saw that the

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[49]Virginia Kasley, "As Life Ebbs," AJN 38 (November 1938): 1191.

[50]Harriet Loomis, "Pemphigus," AJN 47 (November 1947): 735.

[51]M. Ward and E. Robson, "Nursing Care of Fractures," CN 38 (April 1942): 236.

[52]E. Stuart, "Nursing Care in Surgical Conditions of the Urinary Tract," CN 29 (April 1933): 190.

[53]F. Stratton, "To be or not to be Born at Home," AJN 34 (May 1934): 493.

[54]MacDonald, "Empyema," 179; B. Miller, "Nursing Care in Colostomy," CN 33 (February 1937): 60; F. Simpson, "Transfusion Service," CN 47 (January 1951), 16.

patient was as comfortable as possible. Comfort was accomplished by positioning and specific placement of pillows [55], special mouth care[56], bathing and linen changes[57], assistance with turning and eating[58], massage and rubbing[59], ice bags to the head[60], warmth with

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[55]A. Blaricom, "Nursing Care in Pellegra," AJN 38 (May 1938): 513; H. Currier, "Nursing Care in Nephritis," AJN 41 (August 1941): 891; D. Curtis, "The Role of the Nurse in Acute Respiratory Poliomyelitis," NW 128 (October 1954): 12; Hunter, "Thyroid Intoxication," 534; T. McKenzie, "Nursing Care in Thoracoplasty," CN 32 (May 1936): 200; Eula Morgan, "Botulism: A Nursing Care Study," AJN 40 (September 1940): 1043; Magdalen Schroeter, "Empyema," CN 54 (January 1958): 56; Eleanor Pitman, "Nursing Care in Spinal Fusion," AJN 39 (July 1939): 728; Margaret Horn, "Tuberculosis of the Spine II: Nursing Care for Operative Fusion in Children," AJN 34 (September 1934): 848.

[56]K. Barrett, "Intubation in Gastric Surgery," AJN 43 (January 1943): 22; M. Coleman, "Thoracotomy," CN 47 (November 1951): 821; Dolores Gifford, "Acute Pancreatitis," 56 (December 1956): 1584; Norma Killeen, "Cholecystitis and Cholecystectomy," CN 51 (July 1955): 552; Bernice Myers, "Esophageal Diverticulum," CN 55 (July 1959): 616; Maureen Parrent, "Malignant Stomach Ulcer," CN 55 (September, 1959): 836.

[57]M. Brogan, "Nursing Care in Acute Rheumatic Fever," CN 41 (March 1945): 183; H. Fedder, "Nursing the Patient with Sympathectomy for Hypertension," AJN 48 (October 1948): 644; M. Gould, "Nursing Care of the Patient with a Fractured Hip," AJN 58 (November 1958): 1563; Sue Harper, "Continuity of Care", AJN 58 (June 1958): 871; Hartley, "Blood Transfusion," 252; Peterson, "Thyroid Patient," 781; M. Sheppard, "Communicable Disease Care," CN 44 (January 1948): 25.

[58]Fedder, "Sympathectomy," 644.

[59]C. Calderwood, "Structural Scoliosis-Nursing Care," AJN 41 (December 1941): 1407; M. Brown, "Nephrectomy," CN 45 (June 1949): 450; Elizabeth Williams, "Migrane Headache," Nursing World 130 (March

blankets, clothing [61] and hot water bottles[62]. As well, comfort was provided by altering the environment through darkening the room[63], tidying[64], or through use of new equipment such as Gatch beds[65] and colostomy deodorants.[66] Nursing staff saw to air mattresses on beds[67], sought out unchipped bedpans and padded them[68],

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1956): 12.

[60]E. Smith, "Nursing Treatment in Toxic Psychosis," CN 39 (July 1943): 463.

[61]E. Chatham, "A Patient From Persia," AJN 32 (May 1932): 578; Holmquist, "Arthritis," 303; Nell Mills, "Nursing Care of Malaria," AJN 42 (February 1942): 133; G. Post and K. Mason, "Nursing care in Cleft lip Repair," AJN 48 (December 1948): 769.

[62]Chatham, "Persia," 578; Holmquist, "Arthritis," 303; Nancy Jones, "Polyarthritis-Nursing Care," AJN 39 (March 1939): 297; Mills, "Malaria," 133; L. Weed, "Hypertensive Cardiovascular Renal Disease," NW 127 (October 1953): 24.

[63]Williams, "Migraine Headache," 12.

[64]Virginia Brantl, Billye Brown, and Bessie Nemec, "Ben was Severely Burned," Nursing World 132 (August 1958): 15.

[65]K. Bell, "Nursing Care of Children with Heart Disease," CN 42 (October 1946), 856; R. Fellowes, "Nursing Care of Immersion Foot," CN 39 (September 1943): 582.

[66]Sister M. Evarista, "The Nurse's Role in Caring for Patients with Colostomies and Ileostomies," NW 130 (November 1956): 23.

[67]Boylan, "Thoracic Surgery," 140.

[68]E. Patterson, "A Nursing Study of Diabetes," CN 33 (November 1937): 611.

used small fracture bedpans[69], pinned tubing in place[70], and padded cast edges[71], and even occasionally designed new equipment, such as a colostomy irrigation set[72], in the interest of keeping their patients comfortable.

Provision for patient comfort continued to be carried out at times not for reasons of treatment but because it was the moral thing to do. Nursing was a service profession dealing with the mediums "human welfare and comfort".[73] The role of the nursing was to comfort and medicine to cure, and the nurse was "judged always by her ability to make the patient comfortable."[74] Making the patient comfortable remained part of good nursing care.

Comfort Concurrent with Other Nursing Goals

In this time period, as noted previously, comfort

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[69]Lois Nagy, "Cerebral Thrombosis," AJN 57 (February 1957): 213.

[70]Mary Pringle, "Nursing Care of Prostatectomy Patients," NW 127 (September 1953): 16.

[71]Calderwood, "Scoliosis," 1407; Myrl Skinner, "Scoliosis," CN 49 (May 1953): 372.

[72]G. Moorehead, "A Colostomy Irrigation Apron," CN 40 (May 1944): 352, 354.

[73]K. Densford and M. Everitt, Ethics for Modern Nurses: Professional Adjustments I (Philadelphia: W. B. Saunders, 1946).

[74]M. Goodnow, The Technic of Nursing 4th ed. (Philadelphia: W. B. Saunders, 1941)

started to become mentioned more often as a goal concurrent with other nursing goals rather than as the central goal of nursing. For example, statements like "the first principle of nursing is comfort and rest" [75] made the two concepts, comfort and rest, concurrent goals rather than one as prerequisite to the other. Strategies were carried out using warmth for comfort as well as part of burn treatment[76], frequent voiding to increase body temperature and for comfort in fever therapy[77] new equipment such as hyperextension frames[78], respirators[79], Bradford frames[80], Stryker frames[81], and lifting apparatus[82] for physical comfort as well as ease of

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[75]F. Koepsell, "Acute Lobar Pneumonia," AJN 33 (January 1933): 73.

[76]F. Charlton, "The Burn Bed," CN 31 (May 1935): 203.

[77]E. Lehman, "Nursing Care in Fever Therapy," AJN 37 (December 1937): 1318.

[78]A. Dickie, "Orthopaedic Nursing," CN 31 (December 1935): 536.

[79]Barbara Montizambert, "Nursing Care of a Patient in a Respirator," CN 50 (June 1956): 462.

[80]M. Orr, "Orthopaedic Nursing," CN 31 (November 1935): 500.

[81]G. Skinner, "Nursing Care of a Patient on a Stryker Frame," 46 (May 1946): 292.

[82]B. Fash, "The Use of the Liftee," NW 132 (March 1958): 18.

nursing care, and, sometimes, minimization of the number[83] of staff or nursing time required[84].

Mouth care, bathing, and frequent positioning is provided for physical comfort as well as for cleanliness[85], wound or catheter drainage[86], to keep the patient dry[87], support weak muscles[88], avoid chilling[89], and for preventing or relieve compiications such as decubiti[90] and dyspnea[91]. As the period progressed,

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[83]Montizambert, "Respirator," 462.

[84]Skinner, "Stryker Frame," 292.

[85]Myrl Peterson, "Purpura Hemorrhagica," AJN 42 (September 1942): 1019; Johanna Schwarte, "Acute Diarrhea," AJN 42 (May 1942): 515.

[86]S. Ansell, "A Patient With Spinal Injuries," AJN 45 (November 1945): 956; G. Carty, "A Mastectomy," CN 39 (April 1943): 286.

[87]Josephine Bennett, "The Nursing Care of Burned Patients," AJN 37 (December 1937): 1339; Amaryllis Eaton, "Right Lobar Pneumonia," 55 (December 1959): 1109.

[88]M. Ferry, "Nursing Care in Poliomyelitis," CN 34 (April 1938): 178.

[89]Imelda Brunader, "A Child With Post-Rubella Encephalitis," CN 53 (July 1957): 613; Marguerite Martin and Ruby Corzine, "The Nursing Care of Tetanus," AJN 42 (July 1942): 742.

[90]Mildred Blank," Nursing Care in Hodgkins Disease," AJN 48 (September 1948): 563; Caroline Busacker, "The Nurse in Erysipelas," AJN 32 (February 1932): 122; M. Briggs, "Nursing Care of Injuries of the Spinal Cord," AJN 45 (February 1945): 104-105; L. Cady, "Nursing the Aging Tuberculosis Patient," NW 128 (December 1954): 15; Dickie, "Orthopaedic Nursing," 536; E. Ferguson, "Continuous Gastric Drainage," CN 36 (June 1940): 342-343; Harmer, Principles and Practice, 70-76; Sister T. Joseph, "Pott's Disease," CN 43 (January 1947): 65; D.

positioning in correct alignment became increasingly important in preventing contracture deformity as well as for comfort[92], as did postoperative deep breathing and coughing for prevention of pneumonia[93], position

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Kieliazak, " A Patient With Rheumatic Fever," AJN 46 (March 1946): 196; Elizabeth Laturnus, "Infectious Mononucleosis," CN 53 (December 1957): 1103; Patricia Rowland, :Nursing Care in Hemorrhoidectomy," CN 55 (February 1959): 126; Eunice O'Rourke, "Bulbar Poliomyelitis," CN 50 (June 1954): 493; M. Rideout, "Care of the Infant With Pneumonia," CN 45 (January 1949): 19; C. Shaw, "Nursing Care of Patients With Cataract," AJN 48 (March 1948): 154; Gloria Sobie, "Pemphigus Vulgaris," CN 55 (July 1959): 629; Ward and Robson, "Fractures," 233; Wilms, "Banti's Disease," 58.

[91]Ola Baxter, "Nursing Care of Patients with Infectious Hepatitis," AJN 46 (June 1946): 385; Boylan, "Thoracic Surgery," 141-142; Eaton, "Pneumonia," 1109; Rita Fenwick, "Nursing Care in Virus Pneumonia," AJN 43 (February 1943): 145; L. Lincoln, "Thoracoplasty- Nursing Care," AJN 44 (November 1944): 1024; A. McKerral, "A Nursing Study of Paget's Disease," CN 39 (June 1943): 417; B. Rothwell, Nursing Care in Pulmonary Edema," AJN 48 (November 1948): 701; S. Stone, "Chronic Myocarditis," AJN 48 (January 1948): 54; M. Taufic, "Nursing Care of the Cardiovascular Surgery Patient," NW 130 (February 1956): 13.

[92]H. Anderson, "Nursing the Patient With Bone and Joint Tuberculosis," AJN 48 (April 1948): 217; Brogan, "Acute Rheumatic Fever," 183-184; F. Lillian Campion, "Nursing Care of Patients With Poliomyelitis," CN 50 (June 1954): 460; Hargiss, "Nurses Know," 832; Jean Hayter, "Acute Myocardial Infarction," AJN 59 (November 1959): 1603; Sister M. Jane Hofmeyer, "A Cerebral Vascular Accident," AJN 57 (June 1957): 770; Holmquist, "The Patient with a Trophic Arthritis," 304; Keppy, "Heart Failure," 581; Kerr, "Cerebral Palsy," ; Geraldine Skinner, "The Practical Nurse Supports her Patient," NW 128 (April 1954): 17.

[93]J. Anderson, "Tuberculosis of the Hip," AJN 39 (June 1939): 672; Myers, "Diverticulum," 617; Pringle, "Prostatectomy," 15; M. Stephen,"Nursing Care of Burned Patients," AJN 40 (May 1940): 504;

changes[94] and, later, early ambulation[95], for prevention of pneumonia, thrombosis and gas pains. The nurse saw to the patient's comfort and at the same time prevented injury or infection while carrying treatments involving heat or cold[96] or restraints[97], and by using aseptic technique.[98]

Physical comfort seems, in some descriptions, to become a goal secondary to the prevention of complications. Comfort is subordinate to other goals such as prevention of deformity[99], respiratory difficulty[100],

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[94]Anderson, "Tuberculosis,", 672; Myers, "Diverticulum," 617; K. Newton, "The Nurse in Poliomyelitis Care," AJN 47 (June 1947); 371; Pringle, "Prostatectomy," 15.

[95]E. Ferguson, "New Procedures in Gynecological Nursing," CN 45 (July 1949): 519; Bernadette Gillis and Lucetta MacDonald, "An Exploratory Laparotomy," CN 54 (October 1958): 968; Pringle, "Prostatectomy," 16.

[96]Cynthia Van Blarcom, "Nursing Care in Ice Anesthesia," AJN 43 (September 1943): 800; Evarista, "Colostomies," 22; S. Tillman, "Nursing Care of the Patient With Tularemia," AJN 48 (June 1948): 390.

[97]Eve Frieden, "Fever Therapy for Children," AJN 39 (July 1939): 763.

[98]J. Anderson, "Improvised Southey Tube," CN 39 (December 1943): 806; Watanabe, "Carcinoma," 536.

[99]E. Felsing, R. Carson and K. Walker, "Nursing Care in Acute Poliomyelitis," CN 37 (December 1941): 821; Joan Lawrence, "Traumatic Arthritis of the Hip," CN 54 (July 1958): 631; A. McCarthy, "Acute Anterior Poliomyelitis," CN 46 (October 1950): 795; Geraldine Skinner, "The Wheel Chair Patient," NW 128 (July 1954):28; J. Wallace, "Care of the Sick Aged in the Home," CN 47 (February 1951): 118;.

skin breakdown[101], tension on a suture line[102] and urinary infection[103] in postoperative, acute and potentially rehabilitable patients. The emphasis on maintaining function is reflected in the following passage:

> The body must be well supported when being moved and when being placed on a bedpan. The patient must never be allowed to assume a faulty position in an attempt to alleviate pain.[104]

The idea that comfort was the ideal the nurse strove for was being replaced.

Later in the period, strategies are mentioned as being carried out for physical comfort as well as for psychological outcomes. Goals for care included morale[105], reassurance[106], and relaxation[107]. The focus

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[100]K. James, "Nursing the Surgical Patient," 33 (August 1937): 373; Carl Wilson, "Congestive Heart Failure With Uremia," CN 53 (April 1957): 326.

[101]E. Larmour, "Nursing Aspects of Craniopharyngioma," CN 39 (July 1943): 456; R. McLean, "Routine Care of Decubitus Ulcer in Paraplegia," CN 45 (April 1949): 263.

[102]Harriet Wright, "Corneal Transplant and Nursing Care," AJN 46 (January 1946): 35.

[103]Evelyn Osburn, "After Hysterectomy," AJN 59 (February 1959): 242;

[104]Felsing, Carson, and Walker, "Poliomyelitis," 822.

[105]Eleanor Jobes, "The Nurse and the Exposure Treatment for Burns," NW 127 (November 1953), 35.

[106]Viola Surerus, "Acute Laryngotracheobronchitis," CN 53 (July 1957): 605.

on physical aspects of care was changing.

Ability of the Nurse to Comfort Contingent on Physician Orders/Actions

In the 1930's, the number of articles in which administration of medications for pain, ordered by physicians, was described began to spiral. Narcotic analgesics were used especially for postoperative[108] and other types of acute pain[109], as well as sometimes for chronic[110] and terminal[111] pain. Other medications such

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[107]R. Williams, "Congenital Hip Dislocation," CN 53 (July 1957): 621.

[108]C. Betz, "A Study of an Obstetrical Patient," AJN 34 (November 1934): 1111; Boylan, "Thoracic Surgery," 141; Hunter, "Nursing Care in Scoliosis," 14; H. Kolb, "Pancreatitis With Abcess Formation," AJN 35 (June 1935): 557; I. McDonald, "The Nursing Care of Patients Having Gas Gangrene," AJN 35 (April 1935): 305; McKenzie, "Thoracoplasty," 200; M. Mitchell, "Nursing Case Study in Tuberculosis," AJN 33 (December 1933): 1199; D. Riddell, "Lobectomy: The Nursing Care," CN 31 (June 1935): 248-249; Sommermeyer, "Acute Pancreatitis," 1159; F. Wilson, "Nursing Medical Patients," AJN 30 (February 1930): 172.

[109]Blaricom, "Nursing Care in Pellagra," 513; Busacker, "The Nurse in Erysipelas," 124; F. Gidley, "Case Study: Barbituric Acid Poisoning," AJN 34 (December 1934): 124; A. Hanson, "Helping Marjory to Get Well," CN 33 (January 1937): 17; D. Marshall, "Case Study: Right Dorsal, Left Lumbar Scoliosis," AJN 35 (March 1935): 277; F. Meyer, "Agranulocytosis," AJN 34 (April 1934): 352; Charlotte Newton, "Bronchial Asthma," 38 (February 1938): 211; Mary Lou Want, "Tuleremia," AJN 34 (January 1934): 83;

[110]Jones, "Polyarthritis - Nursing Care," 298.

[111]Kasley, "As Life Ebbs," 1192.

as salicylates[112], insulin[113], ephedrine sulphate[114], whisky and paraldehyde[115] and local applications of camphor, menthol and albolene[116] were also given for pain and discomfort as were phenobarbital, dial[117] and ether[118] in labor.

In the 1940's and 1950's, analgesics continued to be widely described as used for relief of post operative[119]

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[112]L. Hostman, "Undulant Fever," AJN 34 (August 1934): 758.

[113]Josepha Lott, "II. Nursing Care in Morphine Addiction," AJN 37 (October 1937): 1083.

[114]Newton, "Bronchial Asthma," 211.

[115]Lehman, "Fever Therapy," 1319.

[116]Marshall, "Scoliosis," 277.

[117]Betz, "Obstetrical Patient," 1111.

[118]Stratton, "Born at Home," 493.

[119]Alexander, "After Breast Surgery," 1572; G. Barton, "Colostomy in a Child," CN 45 (July 1949): 504; Carty, "A Mastectomy," 286; Sister E. Clare, "Gastric Ulcer," CN 43 (July 1947): 556; Coleman, "Thoracotomy," 822; Marilyn Cooper, "Cirrhosis of the Liver," CN 53 (December 1957): 1112; Demko, "Staphylococcal Pneumonia," 973; Doreen De Souza, "Acute Glaucoma," CN 54 (July 1958): 645; Eldridge, "Peptic Ulcer," 116; P. Foster and others, "Bandl's Ring," CN 52 (April 1956): 267; Chizuko Furuya, "Placenta Accreta," CN 49 (February 1953): 108; L. Garland, "Arteriovenous Aneurysm," CN 42 (October 1946): 898; E. Gay, "Biliary Obstructive Cirrhosis," CN 42 (March 1946): 239; J. Gregory, "Gastroenterostomy," CN 48 (June 1952): 492; H. Hale, "Chordotomy," NW 128 (March 1954): 13; B. Henderson, "Hyperparathyroidism," CN 47 (December 1951): 899; R. Hislop," Nursing Care of Patients With Mouth or Throat Cancer," AJN 57 (October, 1957): 1318; Betty Hutcheson, Kathryn Gordon, and Flora Morrison, "Rickets," CN 50 (April 1954): 312; Sister M. Jean, "Brain Tumor...Before and After Surgery," NW 128

and other acute pain[120]. Not all pain could be totally relieved so the idea of control of terminal pain[121] or minimization of pain in labor[122] and acute illness and trauma[123] was introduced. Other drugs ordered for pain and discomfort were sulphonamides[124], magnesium

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(June 1954): 43; Killeen, "Cholecystisis and Cholecystectomy," 552; Lawrence, "Traumatic Arthritis," 633; Helen Lemieux, "Duodenal Ulcer," CN 55 (February 1959): 112; A. Lever, "The Paraplegia Patient," AJN 46 (October, 1946): 703; A. Lowe, "A Case Study of Acute Pancreatitis," CN 40 (April 1944): 272; Myers, "Diverticulum," 617; E. Peacock and H. Kirkpatrick, "Thoracoplasty Nursing Care," CN 42 (January 1946): 26; Rowland, "Hemorrhoidectomy," 126; Elizabeth Scanlin, "Chronic Obstructed Appendicitis," CN 53 (July 1957): 601; S. Smith, "Ophthalmic Nursing," CN 37 (November 1941): 746; Watanabe, "Carcinoma," 536; Nellie Wheeler, "Thyroidectomy," CN 50 (November 1954): 914; V. Williams, "Pre and Post Operative Nursing," CN 47 (January, 1951): 18; Helen Wilson, "Nursing Care in Gastric Vagotomy," AJN 48 (May 1948): 282; M. Wood, "Bronchiectasis and Lobectomy," CN 45 (January 1949): 57.

[120]J. Campbell, "Nursing Care in Poliomyelitis," CN 47 (June 1951): 411; Eaton, "Right Lobar Pneumonia," 1109; Beverly Grey, "Acute Myocardial Infarction,"CN 53 (July 1957); 607; C. Richard, "Coronary Thrombosis," CN 45 (February 1949): 141; M. Sarsfield, "The Five-Day Treatment for Syphilis," AJN 41 (September 1941): 1046; Van Blarcom, "Ice Anesthesia," 800; Wilms, "Banti's Disease," 56; N. Young, "Snakebite," AJN 40 (June 1940): 659.

[121]Margaret Ferguson, "Nursing the Cancer Patient," CN 54 (November 1958): 1021; Maejanet MacDonell, "Carcinomatosis," CN 48 (September 1952): 747.

[122]G. Bailey, "A Post-Partum Lung Collapse," CN 39 (October 1943): 685.

[123]K. Dyck, "Fractured Skull," CN 44 (August 1948): 667; Montezambert, "Respirator," 463.

[124]C. O'Hanley, "Renal Calculi," CN 41 (November 1945): 881.

sulphate[125], cortisone[126]. The key word used in this data referred more often to relief of pain rather than the provision of comfort. Comparatively few articles were found describing the reason for giving analgesic and other medications like antiemetics as patient comfort.[127]

Throughout the time period when assessment of the need for analgesics is addressed, nurses warned of the habit-forming nature of narcotics[128] and they were still reserved at times only for severe pain[129]. Orders for administration of placebos prescribed for patients who continually requested narcotic analgesic late in the post-

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[125]H. McCallum, "A Clinical Study of Nephritis," CN 37 (November 1941): 757.

[126]Mildred Fleming, "Rheumatic Fever and Cortisone Therapy," AJN 56 (June 1956): 729.

[127]Phyllis Bakken, "A Normal Delivery," CN 53 (July 1957): 617; Colt, "Aortic Graft," 13; D. Diller, "Nursing Care in Esophageal Operations," AJN 47 (December 1947): 812; J. Juleff, "Hysteria," CN 45 (December 1949): 926; G. MacLennan, "Dietary Treatment of Duodenal Ulcer," CN 45 (May 1949): 346; Peterson, "Purpura Hemorrhagica," 1022; Pringle, "Prostatectomy," 16; A. Uyede, "Post-operative Nursing Care in the Tetralogy of Fallot," CN 45 (March 1949): 185; Joan Wasserott, "Ectopic Pregnancy," AJN 59 (June 1959): 865; Wright, "Corneal Transplantation," 35.

[128]Josephine Flood, "Nursing in Cancer of the Mouth," AJN 43 (June 1943): 538; Harmer, Principles and Practice, 295-296; Harvie, "Corpus Luteal Hemorrhage," 913.

[129]Hanson, "Helping Marjory Get Well," 17.

operative period were carried out without question.[130] Little data was found on how nurses assessed patients for analgesic need but there was some insight into planning by description of the easing the discomfort of early ambulation[131] or deep breathing and coughing.[132] Nurses also watched dose and frequency in relation to overdosing[133], and administered narcotics in "accordance with the doctor's preference... when her observations inform her the patient is able to tolerate them safely".[134] Final decision of whether the patient could tolerate a narcotic, when the nurse was in doubt, went to the physician.[135]

Physical nursing care measures such as bathing and

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[130]Emily Elnicki, "Surgery of the Gallbladder and Biliary System," CN 50 (July 1954): 555; Ann Yankovich, "One Princess Revived," AJN 57 (June 1957): 769.

[131]Ferguson, "New Procedures," 519.

[132]Fedder, "Sympathectomy," 644; E. Jordison, "Nursing in Chest Surgery," CN 38 (January 1942): 21; Dorothy Johnston, "Infiltrative Duct Carcinoma of Right Breast," CN 55 (August 1955): 742; J. Quint, "Nursing the Patient with Endarterectomy," AJN 58 (July 1958): 997.

[133]Mary Donough, "Nursing care of Patients with Myocardial Infarction," NW 127 (February 1953): 10.

[134]Pringle, "Prostatectomy," 15.

[135]Mary Harold, "Nursing Care of Bilateral Adrenalectomy," NW 127 (September 1953): 14.

sponging[136], rubbing, turning and positioning[137] were carried out in conjunction with the administration of analgesics and other medications to relieve pain and discomfort. Some authors asserted that through "good nursing"[138] such as turning, positioning, pillow and catheter arrangement the nurse could minimize the use of narcotics post-operatively.[139] By the end of the time period other authors had conceded that nursing care alone did not relieve severe pain and that analgesics should be given on time as ordered[140]:

> In addition to the immediate postoperative care given, the nurse must not neglect the routine nursing care, and must keep the patient

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[136]Martha Aldrich, "The Nursing Care of Pleurisy," CN 48 (October 1952): 793; Doris Dougherty, "Human Anthrax: A Case Study," AJN 39 (May 1939): 553; Elnicki, "Surgery of the Gallbladder," 552-553; T. MacKinnon, "Nursing Care in Typhoid Fever," CN 41 (June 1945): 472-473; G. Webster, "Nursing Care of Diabetic Patient," CN 32 (November 1936): 511.

[137]Ruth Evans, "Nursing Care in Osteomyelitis," AJN 40 (September 1940): 971; Robin Klaehn, "Abdominoperineal Resection," CN 50 (October 1954): 830; A. Shanck, "The Nurse in an Intravenous Therapy Program," AJN 57 (August 1957): 1012.

[138]Gillis and MacDonald, "An Exploratory Laparotomy," 968-969; Harmer, Principles and Practice, 295.

[139]Harmer, Principles and Practice, 295-296; Harvie, "Corpus Luteal Hemorrhage," 913; Jordison, "Nursing in Chest Surgery," 17; Jobes, "Exposure Treatment," 18; J. Millsap, "Retropubic Prostectomy: 2. Nursing Care," AJN 50 (July 1950): 438.

[140]G. Park and P. Ben-Ezra, "Pneumonectomy," NW 128 (March 1954): 11; Watanabe, "Intestinal Obstruction," 1028.

> as comfortable as possible. It is impossible, however, to control the pain simply by the routine nursing techniques, and it has been found wise to give the narcotics ordered as frequently as necessary during the immediate postoperative period.[141]

In addition to medication and routine nursing care, prescribed treatments were carried out by the nurse for comfort and the releif of pain. Mustard packs[142], starch poultices[143], sedative baths[144], external heat[145], hot moist fomentations and turpentine stupes[146], diathermy[147], and massage[148], gastric lavage[149], parafin

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[141]Harold, "Adrenalectomy," 14.

[142]C. Babel, "An Operating Room Case Study," AJN 33 (March 1933): 272; Koepsell, "Acute Lobar Pneumonia," 73.

[143]M. Flander, "Nursing Care of Eczema in Babies," CN 36 (December 1940): 799.

[144]Lott, "Morphine Addiction," 1082.

[145]M. McInnis, "Nursing Care in Acute Otitis Media," CN 38 (February 1942): 169;

[146]Babel, "Operating Room," 272; M. Edy, "Acute Peritonitis," CN 42 (April 1946); Evans, "Nursing Care in Osteomyelitis," 970; Harvie, "Corpus Luteal Hemorrhage," 913; E. McTavish, "Lobar Pneumonia," CN 28 (February 1932): 88; Newton, "Poliomyelitis Care," 372; K. Parrish, "Case Study in Cirrhosis of the Liver," AJN 34 (November 1934): 1040; Pitman, "Spinal Fusion," 732.

[147]McTavish, "Lobar Pneumonia," 88; Webster, "Diabetic Patient," 511.

[148]Webster, "Diabetic Patient," 511.

[149]Parrish, "Cirrhosis," 1040; Webster, "Diabetic Patient," 511.

spray and steam inhalations[150] continued to be prescribed for discomfort from a variety of acute illnesses in the early part of the period and occassionally in the 1950's[151]. Hot packs remained as a common treatment for pain in acute polio during the 1940's and 1950's.[152] In the 1940's and 1950's new treatments involving sitz baths[153] and heat lamps[154] were ordered. Throughout the period, rubs with camphorated oil[155] and applications of other externally applied agents[156] or heat or cold[157]

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[150]Hunter, "Thyroid Intoxication," 534.

[151]It should be noted here that not all comfort treatments continued to be carried out exclusively by the nurse. For example, the fomentations used in polio might in some institutions might be carried out by the physical therapy department or by a "lay packer or attendant in the convalescent stage." Newton, "Poliomyelitis Care," 372. See also Campion, "Poliomyelitis," 456.

[152]Campion, "Poliomyelitis," 456; Jessie Stevenson, "The Kenny Method," AJN 42 (August 1942): 905.

[153]Ferguson, "Gynecological Nursing," 519; Elizabeth Harmon, "Nursing Care in Rectal Surgery," AJN 44 (September 1944): 863; Rowland, "Hemorrhoidectomy," 127.

[154]H. Levenick, "Nursing Care in Plastic Surgery of the External Genitalia," CN 38 (October 1942): 786; N. Rieger, "Cancer of the Cervix," CN 53 (April 1957): 304.

[155]Babel, "Operating Room," 272; Bakken, "A Normal Delivery," 618.

[156]Blank, "Nursing Care in Hodgkin's Disease," 563; J. Granke, "Influenza Meningitis," AJN 45 (July 1945): 571; G. O'Kane and A. McCawell, "Lichen Planus," CN 46 (January 1950): 41.

[157]Betz, "Obstetrical Patient," 1114; Fellowes, "Immersion Foot," 582; Yoder, "Scarlett Fever," 145.

were given, and post-partum or post-operative binders[158] applied and bladder irrigations and catheterizations[159] carried out. Oxygen was used for the relief of dyspnea[160], and enemas and rectal tubes[161] were used for the discomfort of nausea, vomiting, and abdominal distention.

Further physician control of nurse comforting can be found in data showing usually routine nursing measures such as positioning[162], the number of pillows[163], bedcovers, frequency of turning,[164] bathing[165],and

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[158]Bakken, "A Normal Delivery," 618; Agnes Cantwell, "Gastric Cancer: 2. Nursing Care," AJN 56 (November 1956): 1422; H. Shelton, "Obstetrical Case Study," 33 (May 1933): 495.

[159]Kasley, "As Life Ebbs," 1192; O'Hanley, "Renal Calculi," 882; Watanabe, "Epidermoid Carcinoma," 536;

[160]Amy Brown, "Coronary Occlusion- Nursing Care," AJN 42 (March 1942): 248; Hayter, "Acute Myocardial Infarction," 1602-1603; G. McLagan, "Nursing A Thyroidectomy Patient," CN44 (March 1948): 176.

[161]Babel, "Operating Room," 272; Bell, "Heart Disease," 857; E. Cluster, "Orthopedic Case Study," AJN 32 (February 1932): 214; Harvie, "Corpus Luteal Hemorrhage," 913; McTavish, "Lobar Pneumonia," 88; Parrent, "Malignant Stomach Ulcer," 838; Pitman, "Spinal Fusion," 732; Scanlin, "Chronic Obstructive Appendicitis," 601-602.

[162]Campbell, "Poliomyelitis," CN 47 (June 1951): 411; Cover, "Eye Surgery," 498; Smith, "Ophthalmic Nursing," 746; Taylor, "Comforts for Cardiac Patients," 769.

[163]J. Masten, "Nursing Care in Poliomyelitis Following Isolation Period," CN 34 (May 1938): 251.

[164]Anderson, "Tuberculosis," 672.

shaving[166] came to be specifically ordered for some post-operative, as well as polio and terminal, patients. Access to new equipment and treatments such as modified Bryants frame,[167] Stryker and Bradford frames,[168] and pelvic slings[169] for orthopedic patients, Bunyon Bags[170], ointments and dressings[171] for burns, gastric suction machines[172] and the newest type of respirator for polio patients[173], all of which contributed to the comfort of patients under the care of nurses, were under medical control as therapy. Discontinuation of an

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[165]Cover, "Eye Surgery," 498; Loomis, "Pemphigus," 736.

[166]L. Henderson, "Nursing Care of Patients with Facial Injuries," AJN 57 (April 1957): 455.

[167]Agnes Walter, "Nursing Care of Children Having Recent Fractures of the Shaft of the Femur," AJN 35 (August 1935): 724.

[168]E. Fenwick, "The Stryker Frame," CN 46 (February 1950): 118; Doreen Lent, "On the Ward," CN 55 (October 1959): 916; M. Pickins, "The Patient on a Bradford Frame," CN 46 (February 1950): 116; Skinner, "Stryker Frame," 290-292.

[169]Marion Martin, "Case Study with Autotranfusion," AJN 34 (February 1934): 188.

[170]K. Inch, "The Bunyon Bag Treatment for Burns," CN 39 (March 1943): 194-195.

[171]Bennett, "Burned Patients," 1340; Doris Schwartz, "Pyruvic Acid Paste for Burns,"AJN 48 (May 1948): 284.

[172]Ferguson, "Continuous Gastric Drainage," 344; Tollefson, "Ileac Diversion," 535.

[173]Campbell, "Poliomyelitis," 417.

uncomfortable therapy was also the physician's option.[174] The choice of innovative surgical procedure, treatment method[175] or medication route[176] by the physician also affected patient comfort:

> One great advance in treating this type of fracture is the Smith-Peterson pin. When this method is used, the patient does not require a plaster cast, and in a short time, is allowed to move freely in bed. Consequently, there is little danger of pressure sores and not much discomfort.[177]

There remained, of course, situations in which the nurse could not directly relieve pain and so the role of intermediary, watching for pain and reporting or passing the message[178], remained. She might also have assisted

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[174]Parrent, "Malignant Stomach Ulcer," 838.

[175]Anderson, "Tuberculosis," 672; Frieden, "Fever Therapy," 762; Jordison, "Chest Surgery," 22; Ward and Robson, "Fractures," 233.

[176]Wilcox, "Rheumatic Fever," 98.

[177]Ward and Robson, "Fractures," 233.

[178]H. Bullis, "Pulmonary Tuberculosis," AJN 39 (March 1939): 272; Donough, "Myocardial Infarction," 11; Fedder, "Sympathectomy," 645; Ferguson, "Gynecological Nursing," 519; Hughes, "Intramedullary Nailing," 240; Monette Lindsey, "Traumatic Thoracic Surgery," AJN 44 (November 1944): 1031; McKenzie, "Thoracoplasty," 200; Miller, "Colostomy," 59; Evelyn Pettee, "The Care of the Aged: II. Its Nursing Aspects," AJN 39 (February 1939): 151; Pringle, "Prostatectomy," 16; Carolyn Robertson, "Manual Expression of Urine," AJN 59 (June 1959): 841; Eva Schlesinger, "Nursing the Patient with Crushed Chest," AJN 59 (May 1959): 682-683; Shaw, "Cataract," 155; Wilson, "Congestive Heart Failure," 328; E. Woods, "Nursing Care in Prolapse of the Rectum," CN 40 (December 1944): 959.

with medical procedures which brought comfort[179], played a role in seeking approval for psychiatric referral[180], or overseen a program such as self-medication[181]. Through use of medications, treatments and procedures, much nursing comfort for the patient was passively guided by the medical decisions of the physician.

Delaying Comfort

A great deal of the information during this period focused on changing care and subsequent periods of pain and discomfort the patient faced in order to achieve recovery or avoid further complications and pain. The nurse attempted to minimize the post operative discomfort necessitated by the growing emphasis on deep breathing, coughing, and movement by giving medications prior to these activities as discussed above, or by splinting the incision during coughing.[182] Initial ambulation of

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[179]Allen, "Congenital Dislocation," 723; Anderson, "Improvised Southey Tube," 806; Mary Doris, "Glomerulonephritis," 714, Peacock and Kirkpatrick, "Thoracoplasty Nursing Care," 26-27; D. Thomas, "An Interesting Surgical Case," CN 41 (June 1945): 457;

[180]G. Crane, "The Patient Goes Home." AJN 33 (March 1933): 235.

[181]Marie Parnell, "Medicines at the Bedside," AJN 59 (October 1959): 1417-1418.

[182]P. Bonell, " Understanding Surgical Patients," AJN 59 (August 1959): 1149; Lindsey, "Traumatic Thoracic Surgery," 1030; Quint, "Endarterectomy," 998.

arthritic patients was undertaken for short periods only.[183] During intravenous therapy, careful positioning of the restrained limb was described as a way to minimize the discomfort[184] and later when nurses became responsible for starting the intravenous, the selection of the site was important to comfort.[185]

The technique used to carry out treatments remained important in minimizing discomfort. For example, careful turning of patients was carried out by two or more staff[186], solutions were warmed before injection[187] or instillation[188], massage and alteration of sites employed with multiple injection[189], crusts on dressings and rashes were soaked[190], rectal thermometers inserted

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[183]Rita Ziehran, "Rheumatiod Arthritis," CN 52 (June 1956): 450.

[184]H. Blackman and I. Seeley, "Use of Restraints in Care of Medical and Surgical Patients," AJN 45 (August 1945): 634; I. Merrill and L. O'Neal, "Nursing Care of the Patient with Peptic Ulcer," AJN 46 (August 1946): 521; Taylor, "Physical Comforts," 282.

[185]Shanck, "Intravenous Therapy," 1012.

[186]McKenzie, "Thoracoplasty," 200; Pickens, "Bradford Frame," 116.

[187]Martin and Corzine, "Nursing Care of Tetanus," 741.

[188]McInnis, "Acute Otitis Media," 169.

[189]J. Thomson, "Tetanus," CN 43 (February 1947): 146.

[190]C. Munro, "Gentleness and Skill," CN 26 (December, 1930): 653; Gidley, "Barbituric Acid Poisoning," 1214.

properly,[191] use of as small a caliber rectal tube as possible,[192] and reusable straps, rather than adhesive used for frequent dressing changes[193]. In addition, routine care such as keeping the patient as comfortable "as possible" during a treatment with warmth[194] or an ice cap to the head[195], observation for proper adjustment of traction weights[196], and head and abdominal support of a child with whooping cough[197] aided in minimizing discomfort.

In spite of this, some discomfort was still unavoidable and nurses dealt with this in various ways. They explained to patients that the pain from a treatment was slight compared to the relief that would be gained[198] or explained its purpose.[199] Nurses encouraged[200]

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[191]Frieden, "Fever Therapy," 763.

[192]Harmon, "Rectal Surgery," 860.

[193]Parrish, "Cirrhosis," 1040.

[194]Wilson, "Congestive Heart Failure," 326-328.

[195]Vanderschuur, "Sulfonimides," 40.

[196]Marshall, "Scoliosis," 276.

[197]Choate, "Whooping Cough," 1035.

[198]Bernice Gardner, "Nursing Care During the Administration of Rectal Anesthesia," AJN 31 (July 1931): 795.

[199]Rothwell, "Pulmonary Edema," 701; J. Spinney, "Buerger's Disease: A Nursing Care Study," AJN 49 (February 1949): 121.

patients while they were going through discomfort of post operative coughing[201],and later deep breathing and coughing[202], positioning[203], and exercises[204] or through other painful treatments.[205] In pediatrics, they warned children of pain[206] as well as restrained them.[207] Sometime nurses simply continued with the treatment in spite of pain and discomfort.[208] Immediate comfort was

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[200]The exact way of encouraging patients was not described by any authors although one could speculate it was verbal encouragement.

[201]McKenzie, "Thoracoplasty," 200.

[202]Killeen, "Cholecystitis and Cholecystectomy," CN 51 (July 1955): 551; Mary Stewart, "Nursing Care in Mastectomy," CN 48 (July 1952): 550.

[203]J. Trenholme and F. Gass, "Nursing Care of the Amputee," CN 44 (November 1948): 889;

[204]Marjorie Gould, "Internal Derangement of the Knee Joint: 2. Nursing Care," AJN 56 (May 1956): 582; Lincoln, "Thoracoplasty," 1027; E. Wortham and G. Ritchie, "Nursing Care of Children After Open Heart Surgery," AJN 58 (February 1958): 204.

[205]Spinney, "Buerger's Disease," 121.

[206]E. Badgeley, "Making Friends with Children," 57 (December 1957): 1559.

[207]L. Destromp, "Post-Operative Care of Cleft Palate," CN 38 (July 1942): 478; Laturnus, "Infectious Mononucleosis," 1103.

[208]D. Macham, "The Nursing Care of Burns," CN 39 (February 1943): 112; K. Magee and M. Peacock, "A Difficult Case," CN 38 (April 1942): 254; G. Peterson, "A Method of Treating Burns," AJN 50 (December 1950): 786; E. Tracey, "Meningitis," CN 44 (March 1948): 212; Want, "Tularemia," 82-83; Williams, "Congenital Hip Dislocation," 622.

not the main goal of nursing here, and minimizing the immediate discomfort was a minor strategy in achieving other nursing goals, including carrying out prescribed treatment.

Physical Comfort Through Non-Physical Approaches

Although the majority of strategies to achieve physical comfort continued to emphasize physical techniques such as positoning and bathing discussed previously, there were still non-physical strategies used. Sympathy continued to be used in conjunction with other techniques such as reassurance[209], a "tender touch"[210], patience and understanding.[211] The word reassurance began to appear in nursing literature in the 1930's and was used as a technique to achieve patient comfort and pain relief on its own[212] or later in combination with other techniques like encouragement[213],

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[209]Busacker, "The Nurse in Erysipelas," 123; Flood, "Cancer of the Mouth," 538.

[210]Busacker, "The Nurse in Erysipelas," 123.

[211]Yoder, "Scarlet Fever," 147.

[212]H. Fedder, "Nursing Care in Trigeminal Neuralgia," AJN 48 (June 1948): 370; Jones, "Polyarthritis - Nursing Care," 298.

[213]Cantwell, "Gastric Cancer," 1422.

listening and talking[214], and explanations.[215] Explaining the purpose[216] of various treatments, surgical procedures and tests[217] or the reasons for pain and discomfort[218] had become a comfort strategy as well as a strategy to obtain patient cooperation.

Formalization of patient teaching in order to deal with pain and discomfort began with nurses teaching prenatal classes[219] and the use of techniques such as relaxation, feeling small and chest breathing in body

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[214]Irene Nordwich, "Peptic Ulcer," CN 50 (July 1954): 585; Madeline Weiss, "Nursing Care of Psychoneurotic Patients," AJN 46 (January 1946): 41.

[215]Harmer and Henderson, Principles and Practice 5th ed., 716, 1023.

[216]The nurse's explanation might not have been considered to be as thorough as one given by the physician but sufficed in the interim between the time the patient asked a question and the doctor could answer it. An example of this is found in A. Jackson, "Cancer of the Bladder," AJN 58 (February 1958): 250.

[217]M. Applewhite, "Addison's Disease and Cardiac Failure," CN 44 (March 1948): 302; Fedder, "Sympathectomy," 644; Jackson, "Cancer of the Bladder," 250; Pringle, "Prostatectomy," 15; Riddell, "Lobectomy: The Nursing Care," 247.

[218]Levenick, "Plastic Surgery of Genitalia," 787; Verna Rhodes and Anna Shannon, "Nursing Care of the Burn Patient," AJN 59 (September 1959): 1266; Trenholme and Gass, "Amputee," 891.

[219]C. Barrett, O. Barwick, and G. Yeats, "Nursing Care of the Pregnant Patient," CN 39 (September 1943): 583; Christine Charter and Bernice Gordon, "Preparation for Delivery," CN 49 (February 1953): 93.

cast[220], conservation of strength,[221] mouth breathing during examination[222] and letting children give dolls injections to prepare for uncomfortable injections[223].

Emotional Comfort Techniques

Up to the middle of the period nurses were still cautioned, in the interest of mental comfort, not to discuss the patient's condition or his present status[224], to restrict tiring visitors[225] and to divert the patient's attention away from the illness through occupational therapy or other light activities.[226] Questions about the illness were to be directed to the physician and if the patient appeared worried, the nurse was to tactfully ascertain the source of concern and to see it was dealt with through an appropriate channel,

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[220]Anderson, "Bone and Joint Tuberculosis," 218;

[221]Thelma Hill, "Twenty-nine Men," AJN 59 (December 1959): 1718-1719.

[222]Virginia Patterson, "Cancer of the Cervix," AJN 58 (July 1958): 1012.

[223]Surerus, "Acute Larygotracheobronchitis," 605.

[224]Harmer, Principles and Practice 2nd ed., 66; Goodnow, The Technic of Nursing, 81.

[225]Brogan, "Acute Rheumatic Fever," 184; Goodnow, The Technic of Nursing, 80; Harmer, Principles and Practice 2nd ed., 68-69; Loomis, "Pemphigus," 735; McKenzie, "Thoracoplasty," 198.

[226]Harmer, Principles and Practice, 67-68; Loomis, "Pemphigus," 735; B. Miller, "Carcinoma of the Large Bowel," CN 33 (March 1937): 116; Ward and Robson, "Fractures," 235;

such as the social services department.[227]

The nurse's attitude for mental comfort during this period was to be cheerful[228], sympathetic [229] and interested in the patient[230] rather than nonchalant.[231] She was to inspire patient confidence in herself, the physician and or hospital[232] and to take all responsibility for the illness upon herself and away from the patient:

> A nurse should never show doubt, hesitation, uncertainty or indecision in her movement or speech and should remember that she is there to plan, to remember, to decide for the patient, and to relieve him of all responsibility.[233]
>
> If she is the kind of person who is ready to shoulder responsibility for the patient's illness and care, the patient is most often relieved of a great deal of worry and concern over his illness.[234]

Emotional comfort was also achieved by attention to

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[227]Goodnow, The Technic of Nursing, 81; Harmer, Principles and Practice 2nd ed., 65-66.

[228]Kolb, "Pancreatitis with Abcess Formation," 558.

[229]Ella Conzelman, "The Nurse's Role in Mental Hygiene," Pacific Coast Journal of Nursing 35 (October 1939): 595; Newton, "Bronchial Asthma," 213.

[230]Wilson, "Nursing Medical Patients," 170.

[231]Pitman, "Spinal Fusion," 728.

[232]Goodnow, The Technic of Nursing, 81; Harmer, Principles and Practice, 66; Taylor, "Comforts for Cardiac Patients," 769.

[233]Harmer, Principles and Practice, 68.

[234]Taylor, "Comforts for Cardiac Patients," 769.

physical care such as personal hygiene[235], smooth sheets and proper sized pillows[236] and a quiet, unrushed environment[237] as well as other environmental strategies like lighting, freedom from draughts.[238]

There was some indication that nurses were beginning to change the way in which they provided emotional comfort. They were still reminded to be cheerful[239] and sympathetic[240] but there was a shifting from avoidance of open discussions with the patient to dealing more directly with concerns related to the illness. One article published in 1938 and repeated ten years later discussed care of the terminally ill and suggested that the nurse seek an understanding of the patient's personality and attitude toward death.[241] In this article, the support for such an assertion came from quoting the writings of various physicians and one could

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[235]Brogan, "Acute Rheumatic Fever," 183; Taylor, "Comforts for Cardiac Patients," 769.

[236]Florence Elliott, "Emotional Needs of the Cardiac Patient," NW 133 (February 1959): 15.

[237]Brogan, "Acute Rheumatic Fever," 184; Pitman, "Spinal Fusion," 728.

[238]Goodnow, The Technic of Nursing, 80.

[239]O'Rourke, "Bulbar Poliomyelitis," 493.

[240]Ruth Ristau, "The Loneliness of Death," AJN 58 (September 1958): 1284.

[241]Kasley, "As Life Ebbs," 1195; Virginia Kasley, "As Life Ebbs," AJN 48 (March 1948): 171.

speculate that the catalyst for change was from medicine, not nursing. In dealing with mentally ill patients, strategies such as frankness about sexual problems[242] and pointing out undesirable behaviours without censuring the patient[243] were suggested. At the end of this period, Fuerst and Wolff[244] suggest comforting through talking about the patient's feelings once the patient is aware of, that is has been told by the physician, the terminal nature of the illness. Physician control and influence over these changes is evident.

Seeing to the Details

Changes in the language used in describing the place of comfort in nursing care was evident. Some authors continued to assert that attention to the details of comfort were an important part of nursing care[245], although some of those measures could be carried out by trained auxiliary personnel.[246] Other authors used terms

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[242]Conzelman, "Mental Hygiene," 595.

[243]C. Naranick, "The Overactive Patient," AJN 47 (January 1947): 98.

[244]Elinor Fuerst and Lu Verne Wolff, Fundamentals of Nursing 2nd ed. (Philadelphia: J. B. Lippencott, 1959).

[245]A. Hahn, "Nursing Care of Glaucoma Patients," AJN 45 (May 1945): 362; Nora Rieger, "Service," AJN 49 (November 1953): 881.

[246]Hahn, "Glaucoma Patients," 363.

such as "extra"[247] or "simple" [248] when discussing patient physical comfort through positioning and hygiene. Nurses were reminded to have patience in seeing to apparently "inconsequential" demands so important to comfort.[249] There began to be expressed during this period concern about the nurse having time to spend on comfort details:

> We all have our little fads and fancies and I felt that with this old lady, these little comforts meant much to her and that she was entitled to the little bit of petting she seemed to enjoy so much. On the other hand I realized that it was dangerous to give in to her too much, as it sometimes seemed that she directed too completely what I did for her. I learned that in catering to her whims and allowing her to monopolize my time, I was being unfair to my other patient,...[250]

> It is essential that nurses be given adequate time to provide good nursing care, to know their patients, to foster confidence, to do the so-called "little things" that add so much to the comfort and well-being of the patient.[251]

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[247]Helen Creighton, "The Nurse's Role in Cardiac Catheterization," NW 133 (February 1959): 28; Schlesinger, "Crushed Chest," 684.

[248]Gay, "Biliary Obstructive Cirrhosis," 239: E. Pitman, "Hip Injuries and Nursing Care," AJN 40 (April 1940): 397.

[249]Reta Allan, "My Impression of Geriatric Nursing," CN 51 (January 1955): 60.

[250]Patterson, "A Nursing Study of Diabetes," 611-12.

[251]Rhoda MacDonald, "I May be Old-Fashioned but..." CN 49 (November, 1953): 861.

Patient Directed Comfort

Patients directed some minor aspects of their own to physical care. Patients were allowed to assume a position of comfort[252] in conditions where it was not indicated that position had been ordered by the physician. In some cases, patients were allowed some control over their care other that positioning, especially when the patient was seen as "irritable and exacting"[253], "uncooperative"[254] or when their conditions were such that the nurse might cause severe pain with routine care such as in the case of a patient with trigeminal neuralgia[255].

Providing for Comfort Through a Third Person

Early in the period, emotional comfort through a third person quite informal and incidental. Patient to

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[252]Colt, "Aortic Graft," 36; Curtis, "Acute Respiratory Poliomyelitis," 12; B. Dexter and C. Kwong, "Nursing Care of Myasthenia Gravis," CN 39 (February 1943): 114; Donough, "Myocardial Infarction," 10; M. Fullerton, "Meningococcic Meningitis," CN 45 (July 1949): 536; Keppy, "Congestive Heart Failure," 580; MacDonell, "Carcinomatisis," 748; M. Pendergrass, "Nursing Care Study: Tetanus," AJN 40 (August 1940): 929; Stevenson, "The Kenny Method," 905; Wallinger, "Heart Disease in Children," 10.

[253]A. Brown, "Subacute Bacterial Endocarditis," AJN 44 (January 1944): 11.

[254]Elnicki, "Gallbladder," 555.

[255]Fedder, "Trigeminal Neuralgia," 370.

patient comfort in sanitorium was described as patients learned to "grin and bear it" from others with the same condition[256] and postoperatively if patients were encouraged by ward mates.[257] Comfort by family was not found to be described until the middle of the period where a public health nurse encouraged the wife of a patient to keep him comfortable at home[258] and a hospital nurse acknowledged the comfort a patient got from visitors "When she was allowed to have them."[259] More deliberate emotional and physical comfort through family was beginning to be seen in the 1950s when parents were encouraged to participate in the care of their hospitalized children[260], children called their parents on the phone for comfort[261], and a husband was encouraged

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[256]Yvonne Kozono, "Psychology of Tuberculosis Patients," Pacific Coast Journal of Nursing 34 (July 1938): 412.

[257]Margaret Conrad, "What is Expert Nursing Care?" AJN 47 (March 1947): 162.

[258]I. Barron, "The Diabetic - From a Public Health Viewpoint," CN 42 (February 1946): 122.

[259]C. Fines, "Pemphigus,: CN 45 (May 1949): 381.

[260]Mary Brodish, "The Nurse's Role in the Care of Children with Acute Leukemia," AJN 58 (November 1958): 1573-1574; Barbara Cavitch, "Parents Assist in care of Hospitalized Children," NW 133 (May 1959): 25-26; Pauline Seymour, "Supracondylar Fracture of the Humerus in Children: 2. Nursing Care," AJN 57 (September 1957): 1178.

[261]S. Barker, "Pediatrics, Family Style," AJN 58 (August 1958): 1124.

to stay after his wife's admission until she was comfortable.[262]

Comforting the Family

Little data from the early part of the period, as from the first period, was found to describe the nurse comforting the family. Some suggestion of allowing the family to participate in the care of the terminal patient made in 30's and 40's by one author[263], but this was not reflected in case studies. By the end of the period, physical comfort of the accommodations of parents staying on pediatric units was discussed[264]. Emotional comfort of patient's family was beginning to be acknowledged as part of the nurse's role in comfort in descriptions of praising the care given to the terminally ill at home[265], helping the family as well as the patient feel comfortable with a colostomy[266], and explaining visiting hours to family of critical patients to avoid

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[262]Creighton, "The Nurse's Role in Cardiac Catheterization," 26.

[263]Kasley, "As Life Ebbs," 1198; Kasley, "As Life Ebbs," 173.

[264]Barker, "Pediatrics, Family Style," 1124; Brodish, "Acute Leukemia," 1574.

[265]M. Palmer, "Nursing the Patient with Multiple Sclerosis," AJN 57 (June 1957): 755.

[266]Thelma Ingles and Emily Campbell, "The Patient with a Colostomy," AJN 58 (November 1958): 1546.

"uncomfortable situations".[267]

Failure to Comfort

Failure to provide physical comfort was primarily due to the failure of analgesic to relieve pain,[268] as a complication of an injection,[269] or of the patient refusing to turn or deep breathe.[270] Physical comfort was also not achieved in spite of nursing attempts because of the disease process.[271] This was also the case for the only example of failure to achieve emotional comfort identified, in spite of the continuous presence of the nurse at the bedside.[272] There was little reflection about not achieving patient comfort as it seemed most often to be blamed on factors outside the control of the nurse.

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[267]P. Lee, "In the Middle of the Night," AJN 57 (June 1957): 729.

[268]Patterson, "Diabetes," 560; Martin, "Autotransfusion," 188.

[269]Gardner, "Administration of Rectal Anesthesia," 798.

[270]Furuya, "Placenta Accreta," 108; Ruth Ritter, "Mitral Commissurotomy," CN 51 (September 1955): 691-2; A. Shier, "Nursing - Just Nursing," AJN 33 (April 1933): 319.

[271]F. Chisholm, "Multiple Sclerosis," CN 42 (June 1946): 510; Sister Mary Edmund, "Acute Rheumatic Fever," CN 51 (November 1955): 879; Brown, "Subacute Bacterial Endocarditis," 11.

[272]Elsa Mikulicic, "Poliomyelitis," CN 49 (July 1953): 565-566.

Comfort in Nursing Care

1930-1959

Within the changes in the structure of nursing care delivery, comfort changed from the main focus of nursing to one of many goals or many strategies. In the early part of the period, comfort retained some of its status as the main goal of nursing for acute, convalescent, and terminal cases, but it was also coming to be seen as a prime strategy to the achievement of other nursing goals (Fig. 5). By the end of the period, comfort was no longer nursing's main goal, except in terminal care (Fig. 6). Henderson's influential definition of nursing developed for the International Council of Nurses embraced the concept of rehabilitation as seen in the emphasizing of the patient's return to independence.[273] One physician stated that too much nursing comfort hindered rehabilitation for long term patients[274], although this was refuted by a nurse.[275] Comfort had become only one of

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[273]Harmer and Henderson, Principles and Practice, 5th ed., V. Henderson, The Nature of Nursing, (New York: MacMillan, 1966), 15-17.

[274]F. Burns Roth, "Address," in Report: Canadian Conference on Nursing Canadian Nurses' Association November 4-5, 1957 (University of Ottawa: Faculty of Medicine), 11-12.

[275]Helen McArthur, "Address," in Report: Canadian Conference on Nursing Canadian Nurses' Association, November 4-5, 1957 (University of Ottawa: Faculty of Medicine), 41.

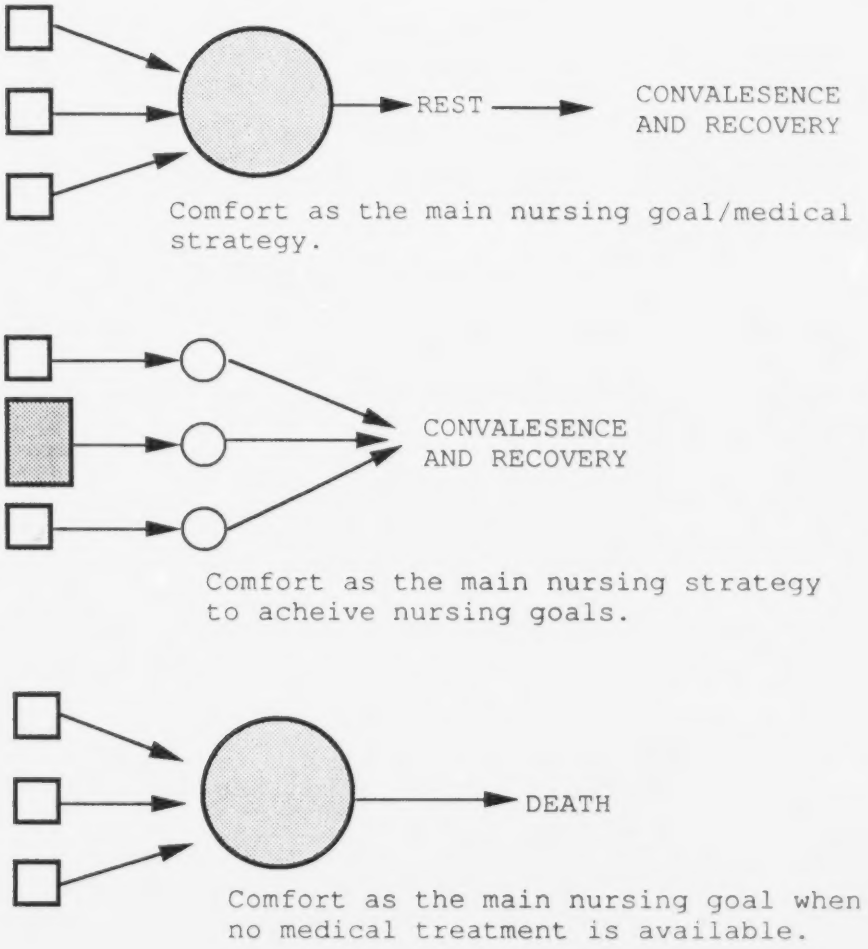
REST
CONVALESENCE
AND RECOVERY
Comfort as the main nursing goal/medical strategy.
CONVALESENCE
AND RECOVERY
Comfort as the main nursing strategy to acheive nursing goals.
DEATH
Comfort as the main nursing goal when no medical treatment is available.

Fig. 5. Main roles of comfort in nursing care identified early in Period 2 (1930-1959): open squares, nursing strategies; shaded squares, comfort as a nursing strategy; open circles, nursing goals; shaded circles, comfort as a nursing goal.

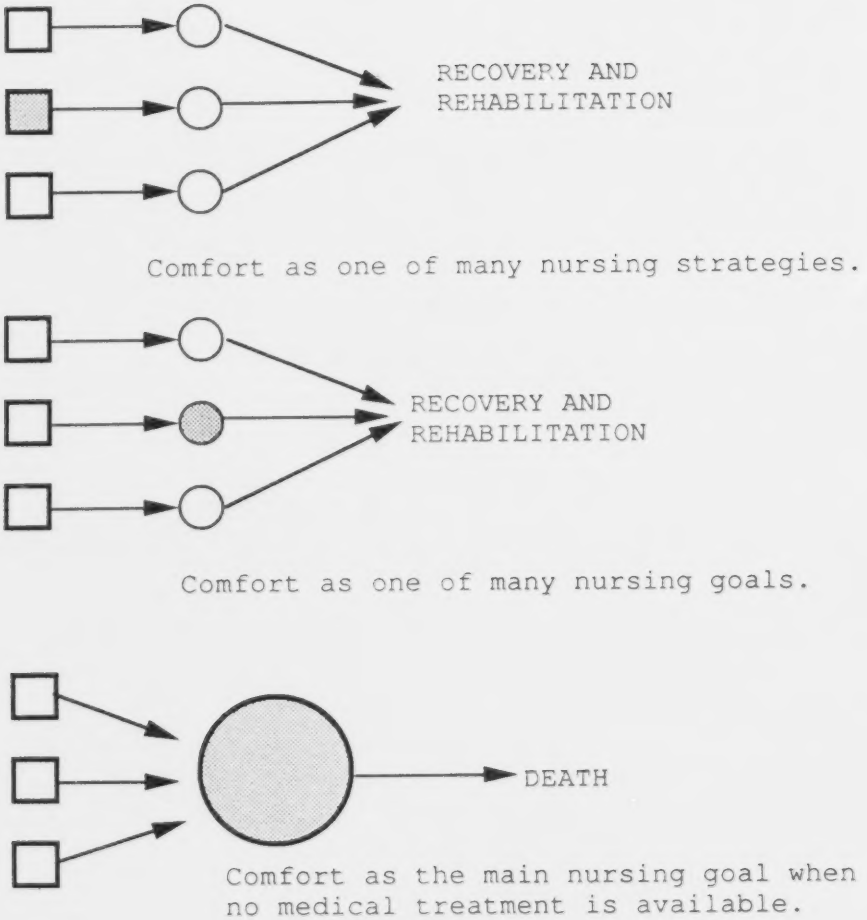

Fig. 6. Main roles of comfort in nursing care identified late in Period 2 (1930-1959): open squares, nursing strategies; shaded squares, comfort as a nursing strategy; open cicles, nursing goals; shaded circles, comfort as a nursing goal.

many nursing strategies and goals.

The nurse's masters were no longer the physician and patient's family but rather the physician and hospital. Here she had many patients to care for and her livelihood did not depend so much on keeping her one patient comfortable, but rather on carrying out the work on the unit efficiently. This concern for efficiency was reflected in some of the data included in the content analysis. She did not have the same amount of time to focus her attention the comfort of a single patient and so comfort strategies began to include the use of others, especially parents in pediatrics. The changes in the nursing strategies for comfort in this period can be seen in Fig. 7 and Fig. 8. Early in the period, nurses likely had little contact with families of hospitalized patients because of the widespread use of sanatoriums for convalescence and general restriction of visitors. Hence the relative little emphasis on comforting the family. With the inclusion of psychology in nursing education, the shift away from forbidding the nurse to converse with the patient on the topic of his or her condition began. Rather than providing comfort through avoiding this type of conversation and isolating the patient from visitors, the nurse was beginning to comfort by dealing more directly with patient concerns and to accept more open visiting in some areas like pediatrics.

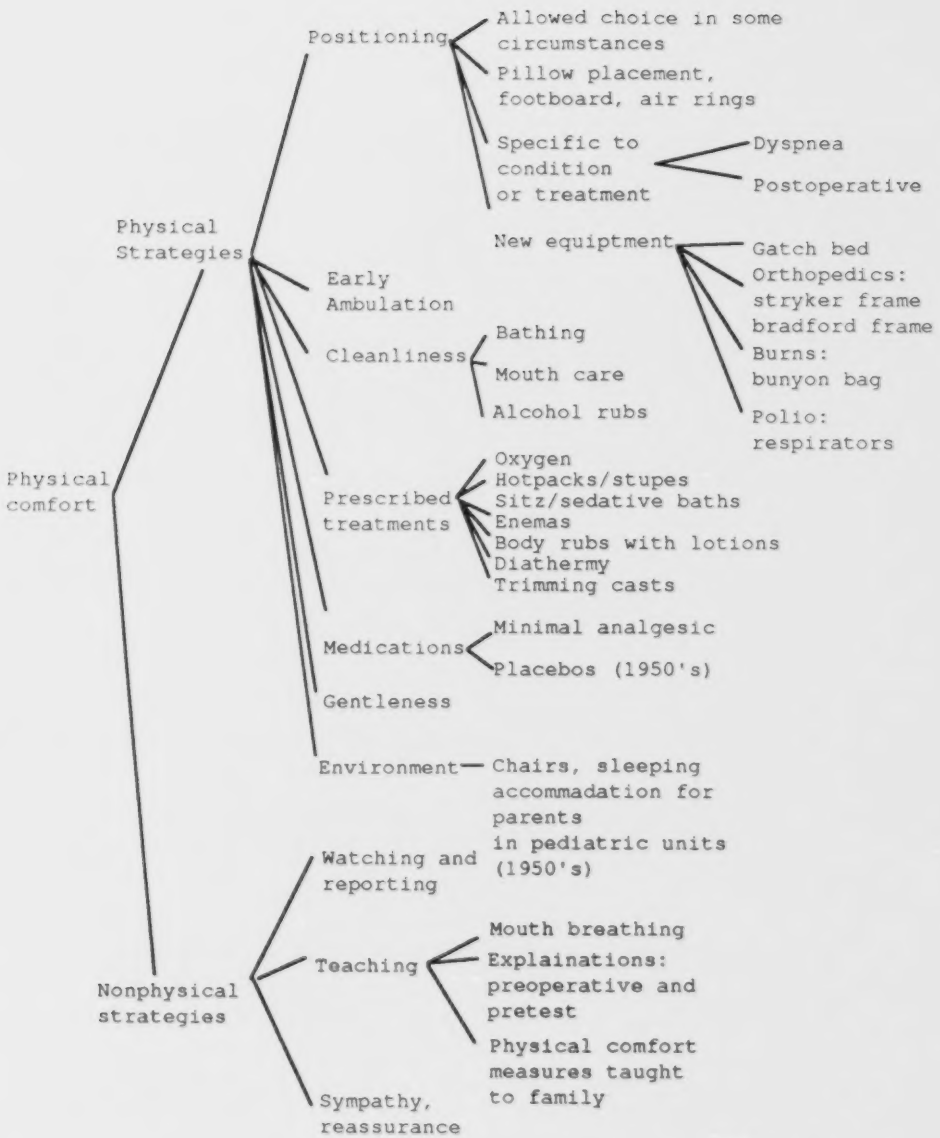

Fig. 7. Taxonomy of physical comfort strategies 1930-1959.

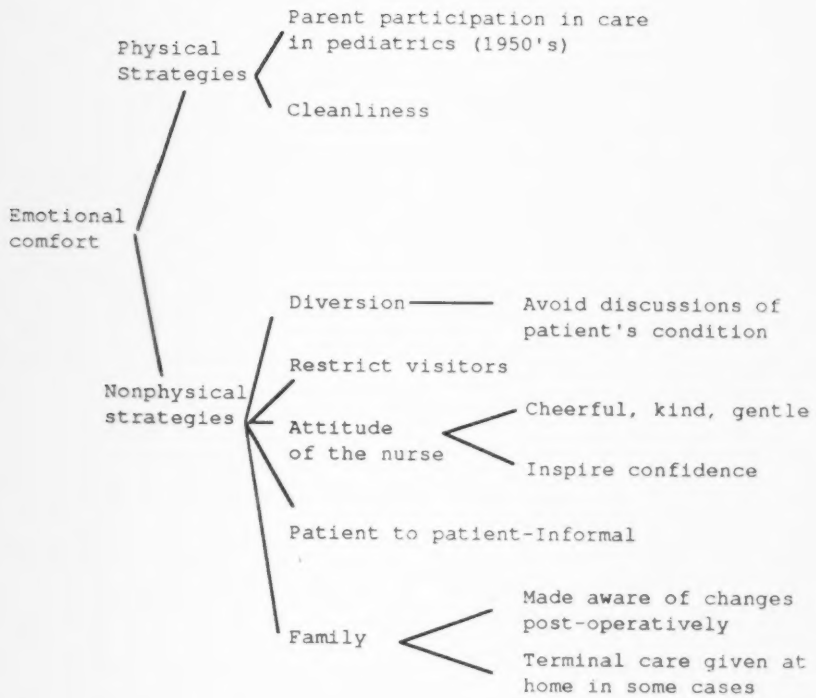

Fig. 8. Taxonomy of emotional comfort strategies 1930-1959.

Control of this change in approach to patients, and of many changes, was under the influence of physicians and hospital boards who set policies. The comfort from the use of new equiptment and medications was intertwined with the choice of medical therapy and again it was the physician, and not the nurse, who made the decisions. Changes in nursing care, and the role of comfort in nursing care, were passively guided by changing medical therapy and the context in which that therapy was carried out.

CHAPTER 6

1960-1980: COMFORT AND THE RISE OF NURSING SCIENCE

With the introduction of the nurse patient relationship and theory, especially from outside of nursing, the role of comfort in nursing care continued to change. Comfort was more often than not one of many nursing goals and strategies. Emotional comfort began to become discussed more often, although physical aspects still dominated.

The Context

Nursing care continued to become increasingly complex as science and technology advanced in the "biomedical revolution,"[1] and nursing functions continued to expand.(Table III) No longer was the nurse's sole focus on seeing that the patient was comfortable. She had to look after monitors, give many medications and supervise other staff. There was simply no time to do everything so the so called simple care was passed on to aides and family as well.

Nursing education in North America continued to move

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[1]Ruth Roemer, "Nursing Functions in Other Countries: Insights for the United States," in The Law and the Expanding Nursing Role 2d ed., ed. B. Bullough (New York: Appleton-Century-Crofts, 1980): 141.

TABLE III

SUMMARY OF CHARACTERISTICS OF PERIOD 3: 1960-1980

NURSING

Education: Slow shifting from hospital to educational institution based programs. Liberal arts and sciences in curriculum.

Employment: Majority of graduates employed in institutions.

Relation to patient:

Nurse-Practical Nurse/Aide/Student-Patient

MEDICINE

Biotechnical revolution. Medical therapies become increasingly technical.

SOCIAL

Consumer awareness grows.

slowly away from apprentice type hospital programs into colleges and university settings[2] with liberal arts and sciences in the curriculum. The effects of changes in education began to show. By the 1970s, there was increased consumer input into the health care system of the United States and nurses had allied themselves with consumers.[3] There was no longer an unquestioning obedience to physician and hospital. With better education, nurses were in a position to question the orders of physicians, as seen in the data, a stand they never would have taken in earlier days.

Categories of Comfort

Comfort as a Prerequisite to a Goal or a Strategy

Physical comfort remained as a nursing goal, although not necessarily the central goal, prerequisite to achieving a medical therapy of rest in those cases where rest continued to be prescribed[4]. It was still occasionally acknowledged to have a role in promotion of

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[2]Canadian Nurses's Association, The Leaf and the Lamp (Ottawa: Canadian Nurses's Association, 1968), 94; P. Kalisch and B. Kalisch, The Advance of American Nursing (Boston, Little, Brown, Co.,1986), 601-605.

[3]Paul Starr, The Social Transformation of American Medicine, (New York: Basic Books,Inc., 1982), 416.

[4]Mildred Crawley, "Care of the Patient with Myocardial Infarction," AJN 61 (February 1961): 69.

a speedy recovery.[5] As in the previous period, physical comfort was still discussed as a strategy to achieve nursing goals other than prescribed rest in that it was prerequisite to successful breast[6] or bottle[7] feeding, eating[8], elimination[9], as well as rest (physiological, not prescribed) and sleep.[10] Seeing to physical comfort and pain relief was also important to the success of

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[5]M. Bowman, "The Nurse and the Patient," NT 71 (July 17 1975): 1147.

[6]R. Bradley, " A Spinal Bifida Baby," NT 68 (February 3 1972): 147; Sister Angela Murdaugh, "Helping the Breast-Feeding Mother, AJN 72 (August 1972): 1421; F. Roberts, "The Child with Heart Disease," AJN 72 (June 1972): 1084; S. Westgate-Smith, "A Normal Confinement," NT 60 (September 4 1964): 1137.

[7]C. Dick, "Baby Jane: A Nursing Care Study," NT 62 (May 6 1966): 602.

[8]Anne Trowga, "Terminal Carcinoma of the Lung," NT 73 ((November 24 1977): 1827; Margaret McCrady, "Nursing Care, A Patient With Burns," CN 61 (May 1965): 373-374.

[9]Rosemary Perka, "Umbilical Hernia," 56 (July 1960)" 617.

[10]Sister Anna Barnfield, "Compound Fracture of Femur Complicated by Fat Emboli," NT 72 (March 18 1972): 410; Dorothy Chapman, "One Little Boy With Two Big Problems," CN 66 (January 1970): 37; B. Hartley, "A Patient with Hodgkin's Disease," CN 59 (April 1963): 349; C. Motley, "Convulsions in a Child: A Nursing Care Study," NT 62 (July 22 1966): 974; K. Patterson, "Care in Chronic Illness Using a Health Profile," NT 76 (August 14 1980): 1432; A. Slocombe, "Old People in Hospital," 59 (September 27 1963): 1222.

treatments such as ambulation[11] dressings[12] or rehabilitation of aphasics[13] as well as for ensuring patient relaxation[14]. Physical comfort of the patient came to be articulated as a strategy to achieve relief[15], specifically relief of guilt, mental agony[16] and anxiety[17], in the patient's family. Sometimes physical comfort was a strategy to achieve a goal identified by a framework or theoretical perspective employed by the nurse such as sick role theory[18].

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[11]C. Parsloe, "Ectopic Pregnancy: Nursing Care Study," 60 (September 4 1964): 1149.

[12]A. Audette, "Nursing Care in Cardiovascular Surgery," CN 60 (March 1964): 269; Michael Burns, "Fournier's Gangrene," NT 59 (July 12 1963): 884; J. Collins, "Care of the Colostomy Patient," NW 134 (March 1960): 26; Murielle Rodrigue, "Nursing Care in Varicose Vein Surgery," CN 63 (January 1967): 43.

[13]B. Miller, "Assisting Aphasic Patients with Speech Rehabilitation," AJN 69 (May 1969): 984.

[14]Esther McClain and Shirley Gragg, Scientific Principles in Nursing 5th ed. (St. Louis: C. V. Mosby, 1966), 125; Alice Morrissey, "Rehabilitation in Hemiplegia," AJN 62 (September 1962): 58; Barbara Hibyan, "For a Patient With a Seventh Operation: A Nursing Care Plan," AJN 60 (January 1960): 72.

[15]S. Tancock and T. Hunt, "Fallot's Tetrology," NT 64 ((September 27 1968): 1304.

[16]Sarah Roch, "The Care of the Dying," NT 64 (October 11 1968): 160.

[17]E. Gedge, "Care of Children Undergoing Cardiac Surgery," NT 68 (January 13 1972): 41.

[18]G. Sorenson, "Dependency: A Factor in Nursing Care," AJN 66 (August 1966): 1763.

The nurse strove to make the patient comfortable before leaving to go on to other tasks[19] and comfort, emotional as well as physical, became one of the strategies to achieve a successful nurse patient relationship[20] and the planning of nursing care[21].

Comfort for Comfort's Sake

For terminal patients, comfort often remained the main goal of care[22], the only thing left to do:

> Unhappily, on October 11 Mr. P. was admitted into casualty with coal gas poisoning after attempting to take his own life. Metastases were, by this time, profuse and

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[19]Shirley Christo, "A Nursing Approach to Adult Aphasia," CN 74 (September 1978): 36; Julia Dunning, "A Geriatric Patient," NT 71 (September 25 1975): 1534: Julia Trudeau, "The Nurse and the New Patient," CN 56 (January 1960): 39; Howard Witts, "Who Will Help Him Now?" NT 71 (January 9 1975): 52

[20]Catharine Blacklock, "Nurse-Patient Relationships," CN 56 (February 1960): 150; Janice Carney, "Peripheral Polyneuritis," AJN 60 (January 1960): 82; Bonnie Easterbrook and Beth Rust, "Abortion Counselling," CN 73 (January 1977): 29; Jean Reid, "Controlling the Fight/Flight Patient," CN 69 (October 1973): 33; Alice Robinson, "Communicating With Schizophrenic Patients," AJN 60 (August 1960): 1120; S. West, "A Beginning," AJN 60 (May 1960): 700.

[21]M. Cullinane, "The Blossoming of Rosie," AJN 68 (January 1968): 123.

[22]J. Fox and H. Jenkins, "Hind Quarter Amputation," NT 68 (August 24 1972): 1060; Carol Henry, "A Time to Live and a Time to Die," NT 67 (August 19 1971): 1016; Mary Knipe, "Serenity for a Terminally Ill Patient," AJN 66 (October 1966): 2252; Colleen McElroy, "Caring for the Untreated Infant," CN 71 (December 1975): 26; M. McGrath, "The Care of the Patient in Terminal Illness," CN 57 (June 1961): 567-8; Roch, "Dying," 158.

> there was little we could do but keep him as comfortable as possible. [23]

Usually nurses identified comfort as the goal without using a theoretical model, but occasionally a theoretical perspective, such as the work of Glaser and Strauss[24], was used as a guide in discussing nursing care.[25] The strategies to achieve comfort were mostly physical in nature, although some authors discussed mental comfort[26] and emotional support[27] as part of the comfort provided.

Comfort for comfort sake was also seen not as the main goal of care but as the reason for specific strategies for some terminal, as well as for acute and chronic patients. Strategies to achieve comfort for terminal patients included immediate changing after incontinence,[28] frequent dressing changes,[29] padding a

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[23]Fox and Jenkins, "Amputation," 1060.

[24]As death becomes perceived as inevitable, the goal of care shifts from recovery to comfort. G. Glaser and A. Strauss, Awareness of Dying, (Chicago: Aldine, 1965), 204-25.

[25]Jeanne Quint, "When Patients Die: Some Nursing Problems," CN 63 (December 1967): 34.

[26]McGrath, "Terminal Illness," 567.

[27]Knipe, "Serenity," 2252.

[28]Valerie Willetts-Schroeder, "Sharing the Experience," CN 75 (October 1979): 39.

[29]Jean Fox, "Reflections on Cancer Nursing," AJN 66 (June 1966): 1319.

bedpan,[30] and making the patient comfortable upon completion of some activity such as admission[31] or bathing.[32] Strategies to make post-operative patients comfortable included bathing and sponging,[33] mouth care,[34] turning, positioning,and back care,[35] using pillows,[36] rubber rings,[37] and dressings.[38] Similar strategies were used in other nursing situations as labor patients were also sponged and had pressure applied with

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[30]D. Sharpe, "Lessons From a Dying Patient," AJN 68 (July 1968): 1520.

[31]Jane Gouldstone, "Leukaemia - to live or let die?" NT 75 (May 31 1979): 914.

[32]J. Barnes, "Molly - A Terminal Cancer Patient," NT 75 (June 21 1979): 1042.

[33]M. Issa and B. Yeardon, "Breast Reconstruction," NT 75 (November 15 1979): 1970; Judith Wass, "Nursing the Patient After Heart Surgery," CN 65 (January 1969): 37.

[34]Issa and Yeardon, "Breast Reconstuction," 1970.

[35]T. Chung, "Mitral Valve Replacement and Aortic Valve Graft," NT 70 (September 5): 1376; Angela Hearn, "Wilm's Tumour," NT 63 (September 1 1967): 1162-63; Wass, "After Heart Surgery," 37; R. Woodgra, "Subtrochanteric Fracture of the Femur," NT 73 (December 22/29 1977): 1988.

[36]Collins, "Care of the Colostomy Patient," 28; Hearn, "Wilm's Tumour," 1162-63.

[37]Collins, "Care of the Colostomy Patient," 28.

[38]S. Koch, "Augmentation Mammoplasty," AJN 80 (August 1980): 1484.

the hand to the back[39], patients with high temperature[40] or undergoing blood transfusion[41] sponged, patients with nasogastric tubes given mouth care,[42] arthritic[43] and orthopaedic[44] patients positioned and given back care.

That the nurse made the patient comfortable upon admission[45] or after treatment or care[46] was also brought out in the data. How the patient was made comfortable in these cases is not explained.

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[39]D. Fairs, "Relieving Pain and Discomfort in Labour: The Role of the Midwife," NT 62 (May 1966): 600; Phyllis Pence, "A Long Labor: A Nursing Care Study,: AJN 61 (August 1961): 102.

[40]D. Eglin, "Meningitis - A Pediatric Emergency," NT 70 (April 11 1974): 542; Annina Mayhew, "A Minor Gynecological Operation with Unexpected Complications," NT 63 (January 20 1967): 92-3.

[41]N. Payne, "Hemihepatectomy: A Nursing Care Study," 62 (September 23 1966): 1246.

[42]Eleanor Drummond and Mary Anderson, "Gastrointestinal Suction," AJN 63 (December 1963): 112.

[43]Mary Mead, "Rheumatoid Arthritis," 62 (January 28 1966): 108; Patricia Merrett, "Elderly Patient with Rheumatoid Arthritis," NT 62 (June 24 1966): 829.

[44]Harriet Senf, "Caring for the Patient in the CircOlectric Bed," AJN 60 (February 1960): 230; Sophie Pasternak, "The Patient with a Ruptured Disk," AJN 62 (February 1962): 77-78.

[45]Marjolin Krauss, "A Patient with an Intracranial Tumour," NT 75 (March 22 1979): 481; Slocombe, "Old People in Hospital," 1221.

[46]L. Compton, "A Patient with a Fractured Facial Skeleton," NT 75 (July 19 1979): 1221; A. Jackson, "Living with a Colostomy," NT 75 (January 11 1979): 71.

Comfort Concurrent with Other Nursing Goals

Nursing measures such as turning, bathing, straightening sheets, massage and alcohol rubs[47] for the prevention of skin breakdown, positioning for the prevention of deformity[48] and pressure areas[49], relief of cast pressure to avoid necrosis and paralysis[50], and hygiene and asepsis for prevention of infection[51] were still mentioned by some in conjunction with making the

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[47]R. Cobell, "An 82-year-old man with a Highly Malignant Reticulosis," NT 75 (July 12 1979): 1176; C. Hardin, "Circumcision as a Day Case," NT 75 (August 2 1979): 1306; M. Moncrief, "Problems, Principles and Practices in the Care of Patients in Plaster," CN 59 (November, 1963): 1049; L. Richardson, "Nursing Care of the Patient with Advanced Cancer," CN 59 (April 1963): 358; Roch, "The Care of the Dying," 160.

[48]W. Crook, "Paralysis Following a Stroke: A Nursing Care Study," NT 64 (August 9 1968): 1068; Judith Hendry, "Peter: An Infant with a Myelomeningocele," CN 73 (January 1977): 17; Catherine Pallant, "Acute Nursing Care in the Stroke Unit," CN 72 (February 1976): 19; Senf, "CircOlectric Bed," 230.

[49]M. Braney, "The Child with Hydrocephalus," AJN 73 (May 1973): 830; C. Robertson and P. Murray, "Nursing an Adolescent with Seizures," CN 61 (March 1965): 182.

[50]E. Boegli and M Steele, "Scoliosis: Spinal Instrumentation and Fusion," AJN 68 (November 1968): 2401.

[51]Linda Cronenwett and Janice Choyce, "Saline Abortion," AJN 71 (September 1971): 1756; Audrey Jackson, "A Conduit for Life," NT 76 (September 4 1980): 1566; Marilyn MacDonald, "The Role of the Nurse in Investigative Urological Procedures," CN 59 (September 1963): 829.

patient comfortable. Although comfort continued sometimes to be a concurrent goal with the prevention of complications,[52] it was not used in conjunction with other goals very much any more except with regards to giving mouthcare for hygiene and comfort[53] or post-operative heatlamps sitzbaths, packs and ointments for healing and comfort[54]. For others, the concurrent goal was to control pain and complications such as deformity,[55] increased oxygen consumption,[56] rather than promote comfort.

Some of the shift towards the comfort, or for that matter pain relief, becoming one of many goals nursing care rather than the main goal is detected in data in which a framework was used to organize nursing care. In one report, care was based on Maslow's hierarchy of

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[52]Numerous articles from this time period were found to describe the provision back care and positioning for prevention of skin breakdown and contractures but were not included in the content analysis as they did not contain the key words being sought. Comfort and/or relief of discomfort was not given as part of the reason for giving care.

[53]Richardson, "Advanced Cancer," 358.

[54]Nancy Anderson, "Nursing Care," AJN 60 (May 1960): 668.

[55]Sister Agnes Frenay and Gloria Pierce, "The Climate of Care for a Geriatric Patient," AJN 71 (September 1971): 1748.

[56]S. Simmons and B. Given, "Acute Pancreatitis," AJN 71 (May 1971): 939.

needs, which were identified as nutrition, elimination, rest, oxygen, relief from pain, and prevention of infection.[57] Here relief of physical pain, and not physical and emotional comfort, is part of the focus of nursing. Other frameworks included the word comfort in guidelines for care under sections such as "Rest, comfort and pain", [58] "To prevent trauma and infection and promote safety and comfort",[59] or "providing continuous care to relieve pain and discomfort and provide immediate security for the individual."[60] There was overwhelming emphasis of physical comfort by some nurses in this category. One explicitly suggested that "caring for physical problems be labelled "comfort" and satisfying emotional needs be labelled "caring." "[61]

Ability of the Nurse to Comfort Contingent on Physician Orders/Actions

Discussion of placebos was found only in the early

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[57]J. White, "Yes, I Hear You Mr. H." AJN 75 (March 1975): 412-413.

[58]E. Stuart and others, "Nursing Rounds: Care of the Patient with a Mitral Commisurotomy," AJN 80 (September 1980): 1631.

[59]Moncrieff,"Care of Patients in Plasters", 1048.

[60]Faye Abdellah and others, Patient-centered Approaches to Nursing (New York: The MacMillan Company, 1961), 25.

[61]F. Northup, "The Dying Child," AJN 74 (June 1974): 1066.

part of the period[62] but in contrast to the previous period, this was a discussion of the wisdom of placebo use because of the potential threat to trust if the patient found out. In comparison, another case study related that the nurse told a young girl who "complained constantly of pain"[63] that her antibiotic was a painkiller without any discussion as to the morality of this type of deception. As fears of addiction to analgesics changed, these types of discussions disappeared.

Medications, primarily analgesics, continued to be described as prescribed and given to relieve pain[64] and

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[62]McGrath, "Terminal Illness," 567.

[63]N. Strathie and C. Swanson, "Problems in one Patient's Care," AJN 66 (March 1966): 527.

[64]Emiko Adachi, "Spinal Injury and Paraplegia," CN 56 (July 1960): 621; Diane Brett, Jennifer Jackson and Anne Wright, "Abortion - With Complications," NT 67 (September 30 1971): 1209: C. Brown, "Total Laryngectomy," NT 67 (September 16 1971): 1145; Burns, "Fournier's Gangrene," 884; C. Camunas, "Transphenoidal Hypophysectomy," AJN 80 (October 1980): 1821; F. Cassidy, "Adult Hydrocephalus," AJN 72 (March 1972): 498; Cobell, "Malignant Reticulosis," 1175; P. Collins, "Treatment of Volkmann's Ischaemic Contracture," NT 74 (June 22 1978): 1039; Compton, "Fractured Facial Skeleton," 1221; M. Easterly, "A Treatment for Pressure Sores and Stasis Ulcer," NT 73 (April 14 1977): 520; H. Fernly, "A Patient with Severe Femoral Shaft Fracture," NT 74 (June 15 1978): 994; Frenay and Pierce, "The Climate of Care for a Geriatric Patient," 1747; P. Grant, "Hospitalization and the Elderly Patient," NT 72 (March 11 1976): 380; Hearn, "Wilm's Tumour," 1162; Henry, "Live and Die," 1016; N. Marrow, "The Care of the Anaesthetized Patient," 65 (August 21 1969): 134-135; Mayhew, "A Minor Gynecological Operation," 92; R.

discomfort[65] more often than to provide comfort[66] . Most

McIntyre, "Care of a Patient Following Aorto-iliac Graft," NT 61 (June 18 1965): 826; J. McKay, "The Long Road Home," CN 60 (May 1964): 468; Heather Olsen, "Congenital Absence of Vagina," NT 71 (January 30 1975): 171-2; Ann Pearson, "Fractured Tibia and Femur in an Elderly Patient," NT 65 (September 4 1969): 1134; N. Phelps, "Intermittent Inhalation in Burn Dressings," NT 68 (August 3 1972): 970; G. Prentice, "Crush Injuries of the Chest," NT 63 (April 7 1967): 452; C. Prett, "An Advance in the Treatment of Leg Inequality," NT 75 (January 4 1979): 28; J. Richards, "Nursing Management After Prostatectomy by Closed Drainage and Mannitol Induced Diuresis," NT 62 (September 16 1966): 1215; J. Scott, "Injuries Sustained in a Car Crash," NT 59 (November 1 1963): 1378; H. Scullion, "Nursing Care Study: Colovesicoplasty," NT 67 (July 15 1971): 864; P. Sellers, "Bilateral Perthe's Disease of the Hip," 65 (October 23 1969): 1354; John Sheahan, "Frostbite," NT 59 (January 4 1963): 13; Brigid Sheridan, "After Hemorroidectomy: Postoperative Nursing Care," AJN 63 (December 1963): 90; L. Statham, "Pulmonary Embolism," NT 68 (March 9 1972): 285; J. Stevenson, "A Patient with Carcinoma of the Stomach," NT 75 (June 7 1979): 963; Stuart and others, "Mitral Commissurotomy," 1628; Rosemary Summerford, "Myocardial Infarction," 64 (May 3 1968): 593; D. Vey, "Reticulum Cell Sarcoma of the Left Breast," NT 62 (June 3 1966): 731; Maureen Ward, "Open Heart Operation - 2," NT 59 (March 1 1963): 257; Anne Watford, "Parkinson's Disease Complicated by Fracture," NT 71 (April 17 1975): 607; Westgate-Smith, "A Normal Confinement," 1136; Woodgra, "Fracture of the Femur," 1988.

[65]K. Brown, "Treatment of Hernia at Sholdice Surgery," CN 62 (June 1966): 52; Christine Hancock, "Acute Myocardial Infarction: A Case Study," NT 64 (January 26 1968): 113; M. Kasselman, "Nursing Care of the Patient with Benign Prostatic Hypertrophy," AJN 66 (May 1966): 1029; Brigid Sheridan, "After Hemorrhoidectomy," 90.

[66]G. Hayman, "Nursing Patients Undergoing Surgery for Ulcerative Colitis," NT 61 (February 12 1965): 213; J. Moir, "Nursing Care of Patients on Ventilators," NT 74 (March 1978): 493; J. Perkins, "Nursing Care Study: Fractured Pelvis," NT 74 (August 31 1978): 1446; Maureen Wilson, "Nursing Care Study: Carcinomatosis," NT 74 (January 12 1978): 56.

of the data in which pain was relieved related to acute pain, such as postoperative pain. Nurses gave ordered medications frequently and regularly,[67] especially post-operatively, and at periods planned to coincide with activities[68] as ideas of minimizing pain and discomfort[69] with analgesic and the concepts of prevention[70] or control of pain,[71] especially in the terminally ill, began to take hold. Apprehension about causing addiction to narcotic analgesic[72] were put aside.

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[67]McGrath, "Terminal Illness," 566; Pasternak, "Ruptured Disk," 79; Carolyn Webb, "Tactics to Reduce a Child's Fear of Pain," AJN 66 (December 1966): 2701.

[68]Sharpe, "Lessons from a Dying Patient," 1518; Pearson, "Elderly Patient," 1134; E. Vaterlaus, "A Holistic Approach to Nursing the Patient in Pain," CN 75 (June 1979): 26.

[69]M. Kitt, "A Return to Independence," CN 59 (July 1963): 641; F. McCarthy, "Nursing Care in Obstetrics," CN 60 (September 1964): 881; Perka, "Umbilical Hernia," 617; Richardson, "Advanced Cancer," 358.

[70]Joan Craven and Florence Wald, "Hospice Care for Dying Patients," AJN 75 (October 1975): 1818.

[71]Barnes, "Molly," 1041; Patricia Beard, "Carcinoma of the Ovary," NT 74 (January 26 1978): 141; Gill Garrett, "Left Upper Lobectomy of Carcinoma," NT 72 Occassional Papers (September 23 1976): 29; P. Iredale, "Multiple Malignant Melanoma," NT 70 (October 17 1974): 1613. Pasternak, "Ruptured Disk," 77; Mary Stott, "Care of a Dying Patient," NT 76 (July 3 1980): 1179;

[72]Knipe, "Serenity," 2253; Margo McCaffrey and Linda Hart, "Undertreatment of Acute Pain with Narcotics," AJN 76 (October 1976): 1590-91; Sister Irene Pepin and Del Howe, "Nursing the Patient in Pain," CN 61 (June 1965): 447.

How nurses used their judgment in giving analgesic became more apparent as discussion of assessment of the need for analgesic came to be more clearly articulated. In assessment, the word pain,[73] rather than comfort[74], again became the focus. Nursing measures for physical care such as turning and positioning,[75] early relief of nausea and vomiting,[76] early ambulation postoperatively[77]

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[73]M. Blackwell and S. Roy, "Surgical "Routines" for Profoundly Retarded Patients," AJN 78 (March 1978): 404; Nicole Cave, "What a Little Care Can Do," CN 75 (December 1979): 39; Craven and Wald,"Hospice Care" 1817-18; Peggy-Anne Field, "Relief of Pain in Labor," CN 70 (December 1974): 18-19; F. Gutowski, "Ostomy Procedure: Nursing Care Before and After," AJN 72 (February 1972): 264; J. Jeglijewski, "Target: Outside World," AJN 73 (June 1973): 1025; Barbara Kozier and Glenora Erb, Fundamentals of Nursing: Concepts and Procedures (Reading Massachusets: Addison Wesley, 1979), 583-587; E. Langan, "Nursing Care of Neurosurgical Patients," NT 63 (January 7 1967): 111; Joan Luckman and Karen Sorenson, Medical-Surgical Nursing: A Psychophysiologic Approach (Philadephia: W. B. Saunders, 1974), 562-563; Pepin and Howe, "Nursing the Patient in Pain," 446; Roberta Ronayne, "A Race Against Time: Caring for a Patient with Radiation Enteritis," CN 76 (February 1980): 39; Sharpe, "Lessons from a Dying Patient," 1518, 1520; Simmons and Given, "Acute Pancreatitis," 939; J. Tanguay, "Infant Care Following Cardiac Surgery," CN 60 (March 1964): 280.

[74]Wass, "After Heart Surgery," 37.

[75]H. Alemany and others, "Nursing Grand Rounds: Femoral Allograft," CN 75 (October 1979): 34; M. Alexander, "Intermittent Claudication: A Nursing Care Study," NT 60 (December 4 1964): 1593; Marie DiBlasi and Carolyn Washburn, "Using Analgesics Effectively," AJN 79 (January 1979): 78; Hayman, "Ulcerative Colitis," 213; Simmons and Givens, "Acute Pancreatis," 939; Bonnie Thomas, "Nursing in Rectal Disorders," CN 62 (March 66): 39;

[76]Simmons and Given, "Acute Pancreatitis," 939.

and other elements of "good basic nursing care" such as mouth and pressure area care, warmth, quiet and provision of foods he/she enjoys[78] were used to increase comfort and supplement the medication given for pain. As well emotional care such as listening[79], supporting[80], sympathy,[81] understanding,[82] and empathy[83] were thought to comfort and boost the effectiveness of analgesic.

Access to new equipment, such as beds and mattresses,[84] permission to carry out, alter, or

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[77]Dianne Copple, "What can a Nurse do to Relieve Pain Without Resort to Drugs?" NT 68 (May 11 1972): 584.

[78]Copple, "Relief of Pain Without Drugs," 584; Roch, "Care of the Dying," 159-160.

[79]M. Kaufman and D. Brown, "Pain Wears May Faces," AJN 61 (January 1961): 51; McGrath, "Terminal Illness, "566; Alice Rines and Mildred Montag, Nursing Concepts and Nursing Care (New York: John Wiley and Sons, 1976), 194.

[80]F. Hoff, "Natural Childbirth: How any Nurse can Help," AJN 69 (July 1969): 1452; Kaufmann and Brown, "Pain Wears Many Faces," 51.

[81]Rines and Montag, Nursing Concepts, 194.

[82]A. Mamaril, "Preventing Complication After Radical Mastectomy," AJN 74 (November 1974): 2001;

[83]Alemany and others, "Femoral Allograft," 34.

[84]Adachi, "Spinal Injury and Paraplegia," 621; J. Noonan and L. Noonan, "Two Burned Patients on Floatation Therapy," AJN 68 (February 1968): 317; Senf, "CircOlectric Bed," 228.

discontinue procedures such as traction[85] and catheterization[86], tube or gastrostomy feedings,[87] change drug adminstration routes,[88] and sometimes position of the patient,[89] all of which affected patient comfort, continued to be part of medical decisions about therapy. The number of prescribed treatments carried out for reasons of comfort declined[90], with only instances of post-operative heatlamp,[91] suppository,[92] and oxygen[93] for chronic lung disease being found. The nurse still retained the role of intermediary observer and reporter

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[85]E. Brotchie, "Infantile Scurvy," NT 59 (September 1963): 1209; Pasternak, "Ruptured Disk," 77; Nelly York and Deborah Cowan, "Halo Traction," CN 76 (January 1980): 29.

[86]Naomi Blakely, "Fractured Base of Skull and Cerebral Contusion," NT 59 (April 5 1963): 411.

[87]Roch,"Care of the Dying," 160.

[88]D. Geolot and N. McKinney, "Administering Parenteral Drugs," AJN 75 (May 1975): 790; E. Simpson, "Pneumothorax with Staphylococcal Empyema," NT 60 (March 27 1964): 405-6.

[89]Audette, "Cardiovascular Surgery," 266; Drummond and Anderson, "Gastrointestinal Suction," 112.

[90]This is not to say that nurses no longer carried out treatments but only that the reason for giving the treatment was no longer comfort but something else.

[91]Kasselman, "Benign Prostatic Hypertrophy," 1029.

[92]Brown, "Hernia at Sholdice," 52.

[93]F. McGilloway, "A Case of Chronic Bronchitis, Emphysema, and Corpulmonale," NT 64 (November 29 1968): 1629.

in situations where pain was beyond the control of the nurse[94] or for use by the physician in choosing to prescribe or change analgesic.[95]

The data on physician control of nurse comforting discussed above related to physical comfort and pain relief. Physicians also exerted some control over the emotional comfort a nurse could offer to patients. One of the nurses caring for a terminally ill teenager stated:

> This was my first day with Alice since she had been told. I felt glad she knew and that I could comfort her and answer questions without being evasive.[96]

Emotional comfort could not be given by the nurse until the physician made the decision to inform the patient.

Delaying Comfort

Nurses continued to attempt to minimize the discomfort of treatment and care by using correct

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[94]Burns, "Fournier's Gangrene," 884; Collins, "Volkmann's Ischaemic Contracture," 1039-40; A. Dugas and M. Dorman, "The Decision," CN 59 (June 1963): 563; Janet Malang, "The Difference it Makes," AJN 72 (February 1972): 277; Olsen, "Congenital Absence of Vagina," 171; C. Wade, "It is a Happy Day Today," AJN 71 (April 1971): 771; R. Watt, "Urinary Diversion," AJN 74 (October 1974): 1811.

[95]Brett, Jackson and Wright,"Abortion," 1209; DiBlasi and Washburn, "Using Analgesics Effectively," 74; Field, "Relief of Pain in Labor," 20.

[96]Sister B. Maxwell, "A Terminally Ill Adolescent and her Family," AJN 72 (May 1972): 927.

injection technique,[97] new techniques for uterine massage,[98] gentleness with enemas and rectal tubes[99] and linen changes,[100] obtaining adequate help from other staff,[101] as well as analgesic before moving and coughing and positioning[102] and "splinting" incisions when coughing and turning.[103] Basic care such as positioning and pressure area care also was carried out to minimize discomfort.[104] One unusual finding was a questioning of the need for unnecessary and painful blood tests for untreated infants:

> The Guthrie test for phenylketonuria is required by law on each newborn, but circumstances should be considered. If the child will not be treated for his main medical problem it is unlikely that he will be treated for PKU, making the test meaningless, and an

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[97]Geolot and McKinney, "Administering Parenteral Drugs," 789; M. Pitel, "The Subcutaneous Injection," Canadian Nurse 67 (May 1971): 57.

[98]Fairs, "Labour," 600.

[99]Sheridan, "After Hemorrhoidectomy," 90; Thomas, "Nursing in Rectal Disorders," 38.

[100]Noonan and Noonan, "Burned Patients," 318.

[101]Pasternak, "Ruptured Disk," 79; Webb, "Reduce Fear of Pain," 2701.

[102]Pearson, "Elderly Patient," 1134; Vaterhaus, "Holistic Approach," 26.

[103]Vaterlaus, "Holistic Approach," 26.

[104]Barnes, "Molly," 1041; H. Hallburg, "The Patient with Surgery of the Colon," AJN 61 (March 1961): 65.

extra discomfort for the infant.[105]

When faced with unavoidable discomfort such as post-operative turning, deep breathing and coughing, suctioning and aspirations, the nurse continued to inform, explain[106], encourage[107] and persuade.[108] Sometimes immediate comfort was not compatible with other long term goals of care and medical treatment. The nurse simply had to go on with unavoidable discomfort for the sake of the other goal. Prescribed injections for children had to be given in spite of pain and discomfort.[109] The most comfortable position for a burn patient did not allow for proper alignment and subsequent rehabilitation so alignment, rather than the patient's choice of position, had to be maintained with footboards and pillows.[110] Surgical patients sometimes also had to

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[105]McElroy, "Untreated Infant," 26.

[106]J. Long, "Carotid Thromboendarterectomy," AJN 66 (September 1966) 1971; MacDonald, "Urological Procedures," 830; Moir, "Patients on Ventilators," 494; Anne Nicholson, "Chronic Renal Failure in a Child," NT 75 (June 14 1979): 996.

[107]C. Drain, "The Athletic Knee Injury," AJN 71 (March 1971): 537; Jean Fisk, "Nursing Care of the Patient with Surgery of the Biliary Tract," AJN 60 (January 1960): 54; Rodrigue, "Varicose Vein Surgery," 43; Pasternak, "Ruptured Disk," 79.

[108]Perkins, "Fractured Pelvis," 1446.

[109]Webb, "Reduce Fear of Pain," 2701.

[110]Elaine Lloyd, "Care of a Patient with Burns," AJN 62 (August 1962): 104.

endure short term discomfort in order to gain long term well-being:

> After operations in the cervical area...the surgeon frequently orders that the head of the bed be lowered below the level of the feet for 24-48 hours...This position facilitates bronchial drainage. Secretions drain toward the mouth and can be expectorated with little effort. The nurse must not give in to the patient's pleas to raise the head of the bed, nor add an extra pillow. The patient's comfort may be affected for a few hours but his well-being, and the peace of mind of the surgeon is assured.[111]

The requirements for medical treatment overrode comfort.

Physical Comfort Through Non-Physical Approaches

Strategies for pain and discomfort include the continued use of reassurance,[112] assurance,[113] sympathy[114] and diversion[115] as well as the additional

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[111]Audette, "Cardiovascular Surgery," 266.

[112]Drummond and Anderson, "Gastrointestinal Suction," 109; M. Ohno, "The Eye Patched Patient," AJN 71 (February 1971): 273; Roch, "Care of the Dying," 159; P. Seitz and L. Warrick, "Perinatal Death: The Grieving Mother," AJN 74 (November 1974): 2030; Vaterlaus, "Holistic Approach to Pain," 26.

[113]Mona Eisenstat, "Bronchogenic Carcinoma," CN 56 (December 1960): 1099.

[114]Pepin and Howe, "Nursing the Patient in Pain," 447; Roch, "Care of the Dying," 159.

[115]Northrup, "The Dying Child," 1066; Vaterlaus, "Holistic Approach to Pain," 26.

means such as empathy,[116] support,[117] acceptance,[118] listening, and dissociation.[119] The comfort from the presence of the nurse when the patient was in pain or fears pain was specifically pointed out[120] as it could no longer be assumed. The nurse was to keep the environment quiet and unrushed,[121] as she had been advised to do in previous periods. Patient teaching involved informal explanations preoperatively of the availability of medication for pain and discomfort[122] as well as formal

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[116]Collins, "Colostomy Patient," NW 134 (March 1960): 28.

[117]Sheryl Grove, "I am a Yellow Ship," AJN 78 (March 1978): 414.

[118]Suzanne Kennedy, "Not the Same Man..." AJN 70 (December 1970): 2619; Pepin and Howe, "Nursing the Patient in Pain," 447.

[119]Vaterlaus, "Holistic Approach to Pain," 26.

[120]C. Boyer, "Caring for a Young Addict with Tetanus," AJN 74 (February 1974): 266; Gillian Doherty, "The Patient in Pain: Handing the Guilt Feelings," CN 75 (February 1979): 31; Lois Knowles, "How our Behaviour Affects Patient Care," CN 58 (January 1962): 31; McCrady and Mitchell, "A Patient with Burns," 372; Pepin and Howe, "Nursing the Patient in Pain," 446; Seitz and Warrick, "The Grieving Mother," 2030; White, "Yes, I Hear You, Mr. H.," 413.

[121]Fairs, "Labour," 600; Pepin and Howe, "Nursing the Patient in Pain," 447.

[122]B. Johnston, "Supportive Therapy for the Surgical Patient," CN 60 (July 1964): 664; M. Powers and F. Storlie, "The Apprehensive Patient," AJN 67 (January 1967): 61.

teaching about medications[123] and techniques such as relaxation[124] to cope with pain and discomfort. There was a widening repertoire of comfort strategies the nurse could use.

Emotional Comfort Techniques

Strategies to obtain emotional comfort became more sophisticated and their use was encouraged as expectations changed from the nurse merely cheering the patient up to discussing the patient's condition,[125] a taboo subject in earlier days. In giving support and comfort to the patient undergoing serious procedures she "cannot glibly reassure the patient...that all will be well in a few hours time."[126] Use of interpersonal and communication skills such as listening,[127] reflecting and

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[123]Vaterlaus, "Holistic Approach to Pain," 26.

[124]Elizabeth Stewart, "To Lessen Pain: Relaxation and Rhythmic Breathing," AJN 76 (June 1976): 958.

[125]Knowles, "Patient Care," 31.

[126]Long, "Carotid Thromboendarterectomy," 1971.

[127]Bowman, "The Nurse and the Patient," 1148; Carney, "Peripheral Polyneuritis," 82; C. Chapman, "What can I say? A Christian Nurse's view of Dying," NT 75 (March 22 1979): 488; Ethel Donny, "Imagination in Maternity Care," AJN 60 (January 1960): 48; M. Maki and F. Perlmutter, "Nursing Care in the Management of Abortion," CN 61 (October 1965): 812; D. Moser, "Nursing Care of the Myasthenic Patient," AJN 60 (March 1960): 343; Kay Parley, "A Nursing Approach to Two Types of Neurosis," CN 60 (February 1964): 133; Edgar Smith, "Reassure the Patient," NT 68 (October 1972): 1334; Stott, "Care of a Dying Patient," 1179.

restating meaning,[128] empathy,[129] and having the patient express feelings,[130] and inviting patients to talk about their grief[131] came in to use as part of comforting.

The presence, continued availability[132] and facial expression[133] of the nurse were important to comfort, this time emotional comfort, and it was sometimes the student nurses, rather than the "busier"[134] staff nurses who had time for this. Touch was seen as comforting[135] and an effective way to convey "comfort and caring."[136]

The emotional comfort gained from use of

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[128]J. Craytor, "Talking with Persons who have Cancer," AJN 69 (April 1969): 747; A. Lore, "Supporting the Hospitalized Elderly," AJN 79 (March 1979): 499.

[129]S. Brogden, "Nursing a Dyspneic Patient," CN 62 (April 1966): 31.

[130]Frenay and Pierce, "Climate of Care," 1748; Knowles, "Patient Care," 30-31; L. Smith, "An Experiment with Play Therapy," AJN 77 (December 1977): 1965).

[131]Sister J. Masco, "This one was Different," AJN 67 (September 1967): 1901.

[132]Frenay and Pierce, "Climate of Care," 1748, Mamaril, "Radical Mastectomy," 2003.

[133]Daphne Garland, "The Care of the Dying," NT 64 Occassional Papers (March 15 1968): 358.

[134]Knipe, "Serenity," 2254.

[135]I. Burnside, "The Patient I Didn't Want," AJN 68 (August 1968): 1669; Ohno, "The Eye Patched Patient," 274; Stott, "Care of a Dying Patient," 1179.

[136]Jill Courtemanche, "Death in Emergency," CN 74 (November 1978): 26.

communication skills, presence and touch assisted in recovery[137] and rehabilitation[138]. New attitudes towards patient interaction seems to be reflected in seeing the patient as "part of the team".[139] For example, in terminal care, all persons involved nurse, patient and family members needed to talk about and understand the significance of death in order to meet role expectations, which included comfort and support.[140] The nurse no longer did everything for the patient, as she had in the first period or took total responsibility for the patient, as she had in the second. She instead assisted the patient in working through his or her reaction to illness.

Seeing to the Details

Nursing measures such as positioning, pillow placement, hygienic care as well as listening and explaining came to be referred to during this time period as "simple"[141] basic skills or the "simplest"[142]

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[137]Frenay and Pierce, "Climate of Care," 1748.

[138]Masco, "This one was Different," 1901.

[139]Collins, "Colostomy Patient," 28.

[140]Carol Kneisl, "Thoughtful Care for the Dying," AJN 68 (March 1968): 550.

[141]Bowman, "The Nurse and the Patient," 1148; Garland, "The Care of the Dying," 355; McElroy, "Untreated Infant," 30.

measures. Such basic care was very important in terminal illness,[143] but because of it's simplicity, could be delivered by nursing auxiliaries and part time workers.[144] For critically ill patients, the simple comfort measures for psychological care were discussed briefly after technical care involving circulation, respiration, and fluid balance, but were part of that which made the nurse more than a technician.[145]

Patient Directed Comfort

Patients were still allowed to direct their own physical comfort in positioning[146] where physicians orders did not contraindicate it. Data were also found describing a patient being allowed other means to control

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[142]Vaterlaus, "Holistic Approach to Pain," 26; Wass, "After Heart Surgery," 37.

[143]Garland, "The Care of the Dying," 358; McElroy, "Untreated Infant," 30.

[144]Garland, "The Care of the Dying," 358.

[145]Wass, "After Heart Surgery," 37.

[146]S. Ansell, "Case Conference: 1. The Long Road Back," NT 60 (March 6 1964): 306-307; Brotchie, "Infantile Scurvy," 1210; B. Davies, "Spinal Osteotomy for a Patient with Ankylosing Spondylitis" NT 65 (July 17 1969): 916; Kathleen Davies, "Influenzal Meningitis," NT 67 (August 1971): 1019; J. Groves, "Acute Larygo-Tracheo-Bronchitis in Children," NT 65 (June 12 1969): 744; Hoff, "Natural Childbirth," 1452; A. Jellis, "Pressure Sores: Way of Prevention," NT 72 (February 26 1976: 291; Prentice, "Crush Injuries of the Chest," 452; Stevenson, "A Patient with Carcinoma," 963; Stott, "Care of a Dying Patient," 1179; Wade, "Happy Day," 771; Wilson, "Carcinomatosis," 56.

her own physical comfort through directing her own colostomy care.[147] Some degree of patient direction in emotional comfort was also seen as a psychiatric patient was allowed to terminate an uncomfortable outing.[148]

Providing Comfort Through a Third Person

Increasingly, the emotional comfort from the presence of family members became recognized, especially in the cases of terminal[149], critically ill[150] and pediatric[151] patients as well as in perinatal death.[152] Families of terminal patients were also taught measures

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[147]Knipe, "Serenity," 2252.

[148]Robinson, "Schizophrenic Patients," 1123.

[149]Hartley, "Hodgkin's Disease," 350; M. Oerlemans, "Eli," AJN 72 (August 1972): 1441.

[150]E. Brener, "Surgery for Coronary Artery Disease," AJN 72 (March 1972): 473; Brogden, "Nursing a Dyspneic Patient," 31; Moir, "Patients on Ventilators," 493; Noonan and Noonan, "Two Burned Patients," 317; G. Sibley, "Tracheostomy in a Blind Patient," NT 60 (January 24 1964): 111; Stuart and others, "Mitral Commisurotomy," 1628.

[151]Christine Clayton, "A Child Suffering From Intussusception," NT 65 (January 16 1969): 80; Catherine Cragg and Anja Laine, "Nursing Care of the Child with Purulent Meningitis," CN 68 (July 1972): 30; Elgin, "Meningitis - A Pediatric Emergency," 542; R. Kessler, "Care of a Scalded Child," NT 75 (April 12 1979): 622; Northup, "The Dying Child," 1067; A. Patterson, "The Management of an Infant with Hirschsprungs Disease," NT 67 (September 30 1971): 1204; Strathie and Swanson, "Problems in one Patient's Care," 527.

[152]Masco, "This one was Different," 1900.

for physical comfort or encouraged to provide foods the patient liked.[153] Comfort from family members helped the busy nurse get through her tasks. The presence of the husband during labor allowed the nurse midwife to leave to "attend to other duties" without leaving the patient alone and having the fear of pain "creep in".[154] Similarly, having mothers assist with care such as the of children was comforting as well as a help to the nursing staff as "mother could take more time to feed him lovingly and without interruption."[155] Although nurses recognized the comfort patients received from family, it was not always easy due to physician and institutional rules for that comfort to be permitted. One nurse wrote:

> Eli's mother fought, too. Visiting hours meant nothing to her. She resisted the nurses and she defied the doctors so that she could spend time with her son. At all hours of the day, she would manage to get to his bedside-bringing him the courage and the will to continue his fight to live. For Eli her visits were a joy...Often he would smile his crooked smile and from it, alone, we would know how pleased he was to see his mother, how grateful for her comforting presence.[156]

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[153]Bonnie Jennings, "Blitz Course for a Homecoming," AJN 78 (May 1978): 856; Paula Kobrzycki, "Dying with Dignity at Home," AJN 75 (August 1975): 1312; M. Maxwell, "How to use Methadone for the Cancer Patient's Pain," AJN 80 (September 1980): 1608; Roch, "The Care of the Dying," 160.

[154]Fairs, "Labour," 600.

[155]Northup, "The Dying Child," 1067.

[156]Oerlemans, "Eli," 1441.

The comfort the mother brought gave the patient the strength to fight on.

Patients also received emotional comfort from non-family members. Nurses had a hand in summoning clergy for visits[157] and in seeing to the ongoing functioning of formalized patient help groups.[158]

Comforting the Family

The inclusion of the emotional comfort of the family as well as the patient as a legitimate nursing function began to be explicated.[159] Comfort of the family was sometimes a goal for which some of the same techniques for emotional comfort of patients were used such as touch,[160] acceptance,[161] and participation of parents in

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[157]Bowman, "The Nurse and the Patient," 1148; Henry, "Live and Die," 1016; Maki and Perlmutter, "Management of Abortion," 812; Roch, "Care of the Dying," 158;

[158]Donny, "Imagination in Maternity Care," 48; S. Parsell and E. Tagliareni, "Cancer Patients Help Each Other," AJN 74 (April 1974): 651.

[159]L. Griffen, "Jim - Severe Head Injury," NT 68 (February 1968): 232; O. Rousseau, "Mothers do Help in Pediatrics," AJN 67 (April 1967): 800.

[160]Janice Carson, "Learning from a Dying Patient," AJN 71 (February 1971): 334; Courtemanche, "Death in Emergency," 26.

[161]L. Warrick, "Family-Centered Care in the Premature Nursery," AJN 71 (November 1971): 2137.

care.[162] Making the family comfortable was also used as a nursing strategy in teaching procedures such as injections to mothers[163] and helping new parents move through theoretical phases in learning to parent an ill infant.[164]

Failure to Comfort

Not all failure to comfort, physical or emotional, was blamed on circumstances beyond the control of the nurse. Nurses also looked in on themselves and publicly critiqued nursing care provided to patients:

> Freedom of choice is perhaps one of the greatest physical comforts. Yet it is a rare commodity in some geriatric wards. Nurses decide when the patient gets up, when he has his meals, goes to bed, has a bath, washes, shaves, has physiotherapy, occupation and recreation.[165]

> Following surgery, Mrs Adams was prescribed papaveretum...which enabled her to be pain free and to rest well. Mrs Tanska who had more extensive surgery was prescribed only ...DF118..which...still left her in some pain. Yet nurses did not put forward a case to the doctors so that they would review it. One

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[162]L. Golfogel, "Working with the Parent of a Dying Child," AJN 70 (August 1970): 1678; K. Mulelly, "A Child with Nasopharyngeal Sarcoma," NT 67 (March 25 1971): 350.

[163]M. McClure and A. Ryburn, "Care by Parent Unit," AJN 69 (October 1969): 2150.

[164]Susan Jay, "Pediatric Intensive Care: Involving Parents in the Care of Their Child," CN 74 (May 1978): 30.

[165]J. Orr, "Care of the Elderly Patient in Hospital," NT 73 (July 1977): 1030.

> wonders if this, too, stemmed from the degree of popularity Mrs Tanska enjoyed.[166]

In the first example nurses are criticized for doing all things for the patient and taking away the patients responsibility for himself. In the second, nurses are reproached for failing to question the physician's order, as well as allowing the less popular patient to suffer. In earlier times, nurses would have viewed doing all for the patient as comforting. Now it was detrimental to comfort.

Sometimes emotional comfort was not attained in spite of nurses efforts because of the absence of family members,[167] depression,[168] or rejection of the nurses comfort,[169] in the case of a small child. Emphasis was placed on attempting to achieve emotional comfort though and no longer was the nurse expected to kept herself totally emotionally distanced from the patient:

> Impersonality is another defense ... Emphasizing the impersonal and the scientific permits her to move in and out of the relationship without being inundated by feelings that would be hard to handle ...However, a dying patient will unfailingly

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[166]J. Crow, "Nursing Care Using a Care Plan," NT 73 (June 30 1977): 987.

[167]S. Richardson, "Lacerations to Left Groin," NT 75 (February 8 1979): 236.

[168]Jackson, "Living with a Colostomy," 73.

[169]Alice Nelson, "Why Won't Steve Drink?" AJN 61 (July 1961): 44.

> become aware of...our tendency to withdraw. When he responds by withdrawing, we have lost the opportunity to comfort him.[170]

Comfort, and a meaningful relationship between nurse and, in this case, a terminal patient depended on open discussion between the two.

Comfort in Nursing Care

1960-1980

Comfort had become merely one of several strategies the nurse used to achieve and effective nurse patient relationship and subsequent recovery, or one of several nursing goals expressed as a patient need.(Fig. 9) Often when interpreted in this way, comfort was viewed only in it's physical aspects, such as the relief of pain, and the complex process of emotional comforting was ignored. Early nursing theoretical frameworks used to organize care often subsumed comfort under some other concept such as adaptation[171] Other frameworks attempted to use more nursing orientated concepts such as care and caring,[172]

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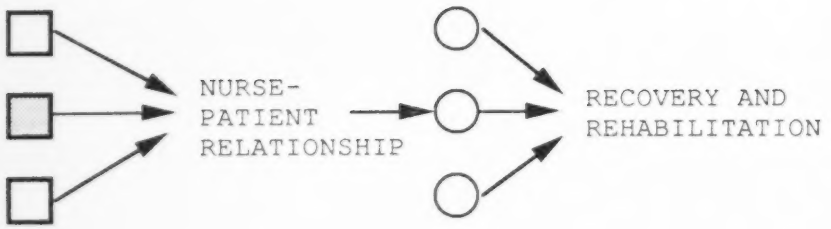
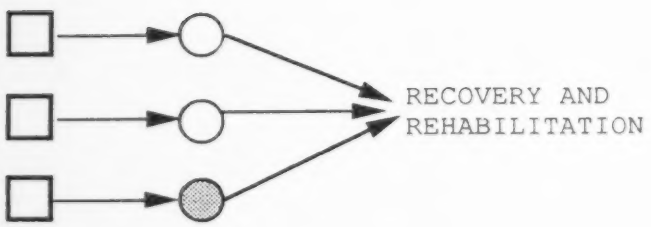
[170]Kneisl, "Thoughtful Care of the Dying," 552.

[171]For example, Levine discussed patient comfort under her adaption principles the "conservation of energy" and "conservation of structural integrity" and saw physical comfort as "supportive" rather than "therapeutic" nursing action. Myra Levine, Introduction to Clinical Nursing 2nd ed. (Philadelphia: F.A. Davis, 1973): 366-7, 373.

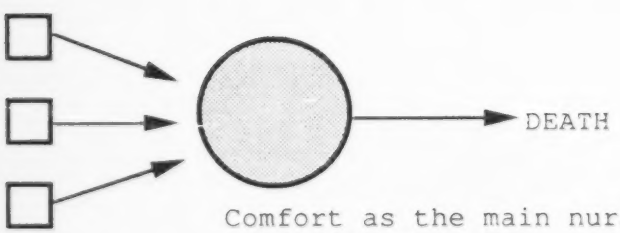
[172]Lydia Hall, "Nursing - What is it?" CN 60 (February 1964): 150; Jean Watson, Nursing: The Philosophy and Science of Caring (Boston: Little, Brown Co., 1979).



Comfort as a strategy to promote an effective nurse-patient relationship and subsequent achievement of goals.



Comfort as one of many nursing goals expressed as needs.



Comfort as the main nursing goal for terminal patients.

Fig. 9. Main roles of comfort in nursing care identified in Period 3 (1960-1980): open squares, nursing stragegies; shaded squares, comfort as a nursing strategy; open circles, nursing goals; shaded circles, comfort as a nursing goal.

under which comfort was subsumed. Care was that which made nursing different from medicine, which cured.[173] Nursing science needed scientific language, not an old fashioned word like comfort. Only when science and technology fail to cure did comfort regain its position as the main goal of nursing care.

Strategies to achieve patient comfort continued to focus on physical aspects (Fig. 10), although the importance of emotional strategies became more pronounced. The taxonomy (Fig. 11) for this time period shows the use of communication techniques taught in the scientific program as well as the inclusion of families in care. Inclusion of families in care stemmed from an increased knowledge of human psychology among nurses as well as time constraints.

The seeming increase in importance of the nurses presence and touch likely due to the difference in the amount of contact between the nurse and the patient. In the early period, the majority of the nurses time was with the patient therefore the importance of her presence did not have to be mentioned. Later the nurse was not with the patient so much as bedside care was being

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[173]Hall, "Nursing - What is it?" 150-153.

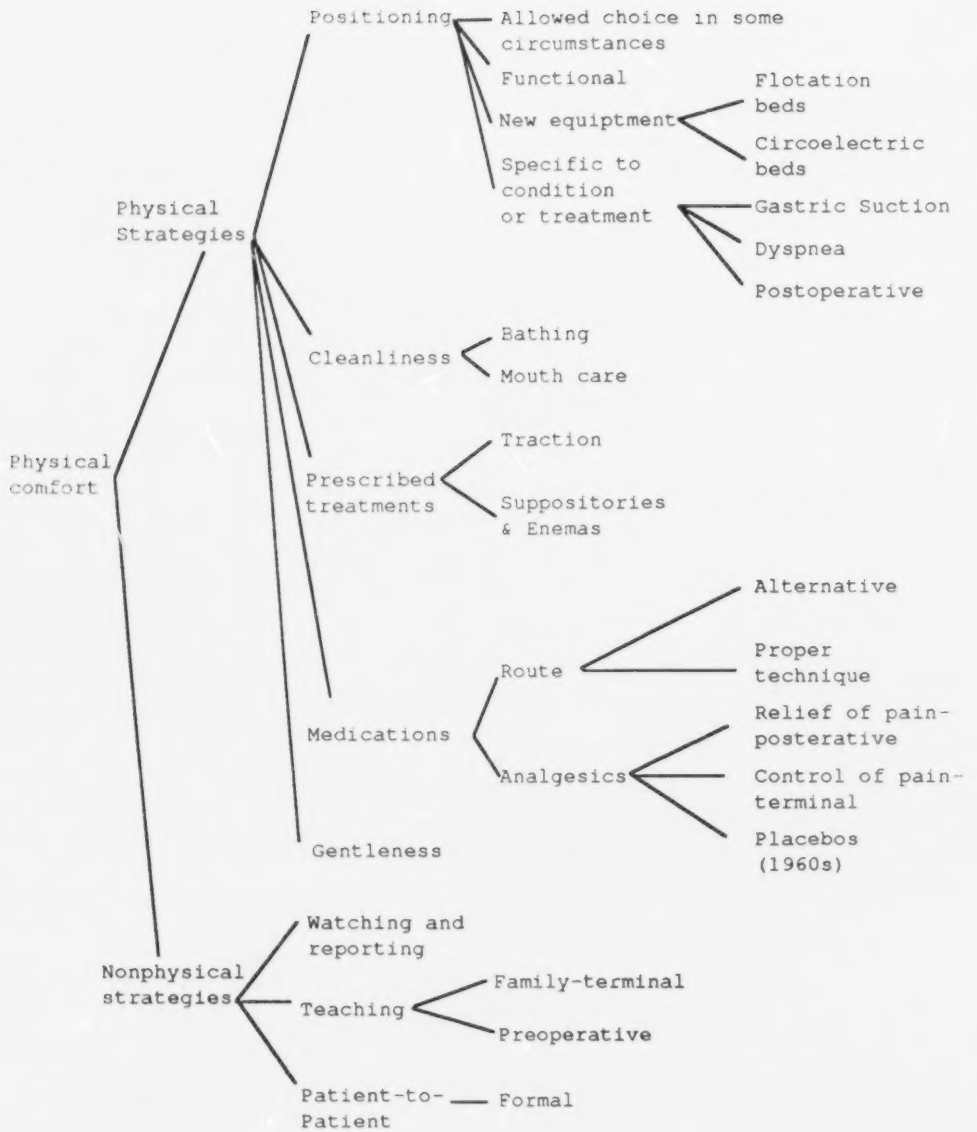

Fig. 10. Taxonomy of physical comfort strategies 1960-1980.

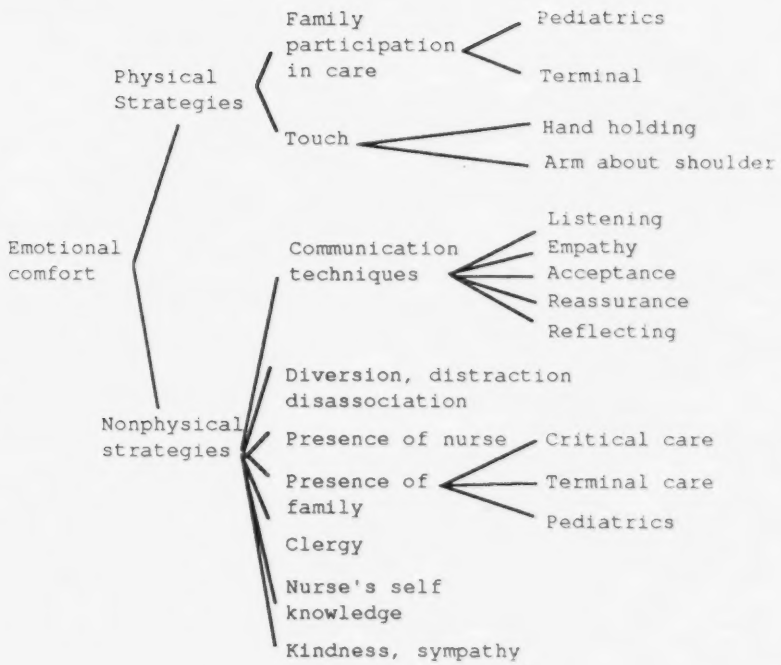

Fig. 11. Taxonomy of emotional comfort strategies 1960-1980.

carried out by nurses aides or practical nurses.[174] Her presence and physical closeness to the patient could no longer be assumed and had to be specifically pointed out.

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[174]P. Kalisch and B. Kalisch, The Advance of American Nursing (Boston: Little, Brown Co., 1986): 599.

CHAPTER 7

DISCUSSION

From the analysis, it can be seen that some elements of comfort in nursing care have changed over the time period, while others have remained stable. There has always been a heavy emphasis on physical comfort, but the importance of emotional comfort became more clearly articulated in nurses writing in the last decades of the study. Emotional comfort evolved from emotional comfort through physical care to more specific emotional comfort techniques.

It is easy to see why some nurses adopted a narrow interpretation of comfort, such as the NANDA nursing diagnosis, which emphasizes so strongly the physical side of patient comfort. The emphasis of most descriptions of nursing care in which comfort is discussed has always been dominated by physical aspects and prescribed therapies, first with the numerous treatments carried out for physical comfort and, in later years, with the increased use of analgesics to relieve pain. However, comfort has increasingly encompassed more that just relief of physical pain.

During the last period, the nurse's repertoire of

emotional comfort strategies increased with knowledge of communication techniques and the recognition by some of the importance of touch and presence as she moved further away from direct patient contact. The nurse was no longer limited, as she had been in the early part of the century, to trying to make the patient mentally comfortable through physical care and diversion and avoiding discussion of the illness, but rather was freed up to make use of new skills to comfort both the patient and the family, in order to improve their ability to deal with the situations they faced.

There was indeed a shift in emotional and physical comfort during the time period studied. This is not like the inverse that Stinson[1] suggested, but was rather a move from almost exclusive attention to physical strategies for physical and emotional comfort to use of psychological as well as physical strategies for emotional and physical comfort. It was due not only to changes in medical care, such as antibiotics, but to developments in nursing education to include psychological aspects of care and recognition of the value of the nurse patient relationship.

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[1]Shirley Stinson, "Deprofessionalization in Nursing?" (Ph.D. diss., Teachers College, Columbia University, New York, 1969), 322-324.

Kolcaba[2] suggested that comfort in nursing care still reflects the idea of strengthening even though this definition of the word has come to be listed as obsolete in present day dictionaries. Historically, there has always been a connection in nursing literature between comfort and the idea of strengthening. Literature from the first and early second periods certainly reflected the connection between physical and mental comfort and patient recovery. It was held that by keeping the patient comfortable, the individual would be in a better position to benefit from medical therapy. Harmer[3] even discussed strengthening as a current dictionary definition of comfort in her 1931 chapter on comfort and connected it to nursing comfort. This connection of comfort, especially emotional comfort, as strengthening remained implied in descriptions of care late in the second period and into the third. For example, parents who were allowed to care for their terminally ill children were comforted by it. It provided opportunity to be with their child and feel they were still effective in how they cared for their child. It helped them cope, or, in other words,

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[2]Katherine Kolcaba, "An Analysis of the Concept Comfort,"Journal of Advanced Nursing (in press-manuscript): 6-7, 18.

[3]Bertha Harmer, Textbook of the Principles and Practice of Nursing 2d ed. (New York: MacMillan, 1931), .

gave them strength. Similarly, for the patient whose mother defied visiting hours, the nurse recognized the strength he gained from her comfort. By the end of the time period studied, this connection between comfort and strengthening the patient in nursing care could still be found in the literature and was acknowledged outright by one nursing theorist.[4]

Comfort, in the early years of this study, was the goal of nursing and, as stated before, a major medical strategy. It is clear from the data that as medical treatment changed, so did the role and significance of comfort in nursing care. As medical therapy demanded less rest and more ambulation and rehabilitation in the second period, comfort, which had been mainly focused on physical care, shifted from nursing's main goal for most patients to a secondary goal or strategy, even an extra. In the third period, as the domination of technology increased, comfort, especially physical comfort, came to be viewed as the simple part of care. Across the time periods of the study, only for patients for whom medical technology had failed or was to no avail, the terminal patients, did comfort continue to be acknowledged as the goal of nursing care.

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[4]J. Paterson and L. Zderad, Humanistic Nursing (New York: John Wiley and Sons, 1976; reprint, New York: National League of Nursing, 1988), 99, Publication No. 41-2218.

As attempts to develop nursing as a science with a theoretical base different from medicine, where nurses cared and physicians cured, comfort became lost in the expansion of language and ideas used by nurses. Nursing frameworks of the last period borrowed concepts from other sciences rather than examining nursing itself in order to identify the elements of nursing care. New terminology was introduced and used inconsistently. Comfort was equated with reassurance[5], while others saw reassurance and comfort occuring together[6], the implication being that they were two different things. The presence of the nurse to some supported[7] or reassured[8] the patient, just as it had comforted in some of the data used in the content analysis. It could be that other words, such as reassurance and support, came to be used as substitutes for comfort by some authors. Further research is needed to compare the frequency of use of such terminology in nursing literature today and

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[5]Edgar Smith, "Reassure the Patient," NT 68 (October 1972): 1335.

[6]C. Parsloe, "Ectopic Pregnancy: Nursing Care Study," NT 60 (September 4 1964): 1147; Robin Radley, "Total Clearance of Pelvic Organs for Carcinoma," NT 64 (December 27 1968): 1749-51.

[7]V. Patterson, "Cancer of the Cervix," AJN 58 (July 1958): 1012.

[8]M. Mason, "Sarah: 40% Scalds," NT 60 (July 31 1964): 987; S. Westgate-Smith, "A Normal Confinement," NT 60 (September 4 1964): 1136.

to determine more precisely whether they mean the same things as comfort to both nurses and patients.

There did not appear to be much diversity among the descriptions of care between the Canadian, American and British literature. In the various time periods there were generally similar elements in the categories from all three countries. Even in the last period, examples were found of British as well as North American nurses using some type of framework to organize care. Despite the great distances and differences in health care delivery systems which evolved, parallels in nursing care, such as the increased use of narcotic analgesic and focus on pain as well as the relegation of physical comfort to the simple part of care occurred. This could reflect a close contact between nurse leaders at an international level as well as the technological changes in health care which influenced all these countries at roughly the same time. Although this study was not designed to compare different groups of literature, the similarity is of interest.

One unanticipated characteristic in the journals searched was the lack of data concerning war casualties, even though the time period covered two major wars and several other smaller conflicts. Virtually no descriptions of war injuries from nurses directly involved in the front lines were found, although some

articles on later care of veterans were found. Published journal articles written by military nurses during wartime tended to be descriptions of the countryside, hospital facilities, or of the difficulties of day to day life. Some of this material was marked as cleared by defense ministries or commanding officers. The nurses might have been censored as to what they could submit for publication as governments were likely not keen about gruesome descriptions of the unfortunate injured soldiers available for public scrutiny.

There were also few descriptions of care found which had been written by public health nurses. Even in the early public health journal, few descriptions of care were found and most of the articles dealt with issues such as hygiene. Since private duty and then institutional staff nursing predominated as the major types of employment for nurses in this century, it is not surprising that the majority of articles in official journals dealt with these types of experiences.

In this study, the descriptions or "care studies" of both graduate and student nurses were included, since both groups were involved in providing care and provided first hand accounts, making them primary sources. No attempt was made to separate and compare the descriptions of the two groups. Future research of a historical nature could be undertaken to study the care studies of just one

of these groups or to compare the characteristics of the two groups to understand any differences in care which may come to light and help understanding of from where nursing has evolved.

This study was also very broad and the taxonomies produced are overviews of nursing strategies for comfort. More specific taxonomies of comfort strategies might have been developed had the study concentrated on one particular group of patients cared for by nurses such as terminal or postoperative patients. Since comfort remained the goal of nursing care for the entire period of the study in terminal cases, focus on this group might have provided present day nurses in palliative care with valuable information about the evolution of comfort for the terminally ill on which to steer future developments in care. Future research of this kind would be valuable.

As broad as the categories and taxonomies are, they are useful in demonstrating the key role that comfort played in nursing care. Even after the significance of comfort declined from being held as the main goal of nursing care to that of one of many strategies and goals, it continued to be refined into a concept encompassing both physical and emotional aspects. Narrow definitions of physical comfort used by some nursing groups and nurse researchers accept only a superficial interpretation of comfort as simple and do not reflect the complex nature

of this concept. It should not suffice to dismiss a concept so fundamental in the development of nursing care as simplistic or to substitute a confusing and imprecise mix of other words for it. Continued research into identification of the present day meaning of comfort for nurses and patients is called for in order to clearly understand and define the concept in a modern sense. Along with this would follow the identification and evaluation of comfort strategies used by nurses today.

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CHAPTER 6

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